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THE RELATIONSHIP BETWEEN TRAUMAGENIC DYNAMIC RESPONSES TOWARDS
CHILDHOOD SEXUAL ABUSE, ETHNIC IDENTITY, SOCIAL SUPPORT, TRAUMA
SEVERITY, AND ATTITUDES TOWARDS INTERPERSONAL RELATIONSHIPS IN
ADOLESCENT FEMALES

BY

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Submitted in partial fulfillment of the
requirements for the Degree of Doctor of Philosophy in Counseling Psychology
Seton Hall University

2014

SETON HALL UNIVERSITY
COLLEGE OF EDUCATION AND HUMAN SERVICES
OFFICE OF GRADUATE STUDIES

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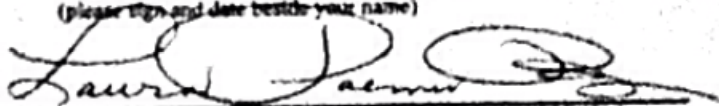
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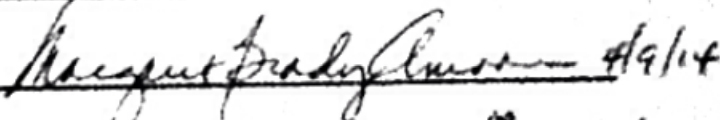
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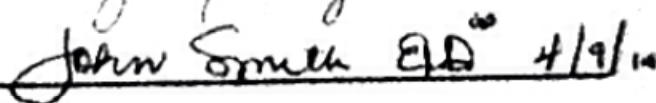
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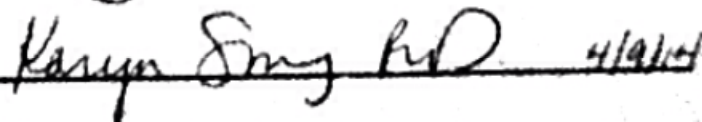
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ABSTRACT

This study used the theory of traumagenic dynamics (TD) to examine how symptomatology resulting childhood sexual abuse (CSA) are related to the attitudes adolescent females have towards interpersonal relationships. The ultimate goal being that this understanding can inform the creation and implementation of empirically based clinical interventions that specifically target CSA-related symptoms which are associated with the endorsement of unhealthy attitudes towards romantic relationships. In examining this relationship, family support and ethnic identity were examined as protective factors against the endorsement of unhealthy attitudes towards romantic relationships, and trauma severity and the presence of domestic violence in the home were examined as a risk factors for the endorsement of unhealthy attitudes towards romantic relationships. Correlational, regression, and hierarchical regression analyses indicated that in this study's sample: (a) TD symptoms were not related to attitudes toward romantic relationships, (b) exposure to domestic violence was not related to TD symptomatology, (c) greater trauma severity predicted a greater level of TD symptomatology but not a higher endorsement of unhealthy romantic relationships, (d) family support and ethnic identity were not correlated, (e) family support and ethnic identity served as a protective factors against endorsing unhealthy attitudes towards romantic relationships, and (f) family support served as a protective factor against experiencing TD symptoms. Findings support investigation of interventions that address trauma severity and attitudes towards romantic relationships and interventions that include family and ethnic community members.

Keywords: child sexual abuse, adolescents, traumagenic dynamics, attitudes, relationships, family support, ethnic identity, trauma severity, domestic violence

DEDICATION

For my family, my parents Jasbeer and Violet, and my brothers Ajay and Anil. Thank you for your belief in me. Throughout all the highs and lows I have always known only unwavering support and encouragement from you.

For my husband, Mark. On the first day of graduate school we were told that achieving this degree would require as much a sacrifice from our partners as from ourselves. How true that is! It is the late night dinners you made me, the editing skills you provided me, and most of all the encouraging words and positive spin you showered me with when things didn't turn out according to plan that let me achieve this milestone. Thank you for all that you have done to support me on this journey. I feel so lucky to be able to share this with you.

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CHAPTER I

Introduction

Child sexual abuse (CSA) is a considerable and serious problem that has been identified as the most significant public health issue in the United States (Anda et al., 2006). CSA involves a range of contact and non-contact offenses, and can be defined as any sexual activity involving a child (Dominguez, Nelke, & Perry, 2001). It is related to clinically significant and emotionally devastating short-term, and possibly also long-term, physical, emotional, social, cognitive, and behavioral consequences (Dominguez, et al., 2001; Kendall-Tackett, Williams, & Finkelhor, 1993; Mullen, Martin, Anderson, Romans, & Herbison, 1996).

Since CSA is not associated with one symptom or one domain of symptoms, the literature in the CSA field has struggled to explain its impact on the functioning of its survivors. As a result, the initial research in this area focused more on the identification of abuse-related symptomatology instead of providing a theoretical foundation explain the impact of CSA. More recently, researchers have put forth theories to organize what has been learned regarding the impact of CSA, but there has been little empirical research to evaluate them (Ramirez, 2009). Such evaluations are important so that appropriate therapeutic interventions can be designed and implemented for survivors of CSA. Among those that have been posited in the CSA literature, Finkelhor & Browne's (1985) traumagenic dynamics theory, which theorizes that CSA results in four traumagenic dynamics that impact the functioning of survivors, is a frequently referenced model for understanding the impacts of CSA. Traumagenic refers to factors that cause trauma. The four traumagenic dynamic factors of the traumagenic dynamics theory are as follows: (a) Traumatic Sexualization, which refers to the child developing dysfunctional feelings regarding sex; (b) Betrayal, which refers to the realization that a trusted adult abused the child or did not

protect her from abuse; (c) Powerlessness, which refers to the child's experience of having her will, desires, and/or control disregarded; and (d) Stigmatization/Self-Blame, which refers to the child incorporating the negative connotations associated with CSA into her self-image.

Relationship-based difficulties have been conceptualized to be a consequence of CSA. Wolfe, Wekerle, Scott, Straatman, and Grasley (2004) reported that child maltreatment is a distal correlate of dating violence, and Coid et al. (2001) reported that children with abuse histories are 3.5 times more at risk of being involved in domestic violence as adults than children who have not been abused. Although researchers have begun to understand the relationship between childhood abuse and abusive relationships in adulthood, it is equally important to understand the relationship between childhood abuse and attitudes towards romantic relationships held by adolescents. This understanding may provide an opportunity for earlier intervention that can prevent relationship abuse later in life.

Additionally, not all children who suffer from maltreatment grow up to experience abuse as adults; therefore, it is also important to investigate both the protective factors that are associated with not experiencing relationship violence later in life, and the risk factors that are associated with the experiencing relationships violence later in life. This can allow for specific targets for prevention and intervention for those who have experienced CSA.

A number of factors are hypothesized to serve as protective factors to guard CSA survivors from experiencing trauma-related symptoms later in life; two of these are social support and ethnic identity status. Researchers have found that a positive perception of social support is associated with fewer psychological, behavioral, and emotional difficulties in survivors of CSA (Tremblay, H'ebert, & Poch', 1999; Vranceanu, Hobfoll, & Johnson, 2007). A positive ethnic identity is associated with psychological well-being (Phinney & Ong, 2007), and has been

associated with resilience (Hackett, Betz, Casas, & Rocha-Singh; Holleran & Waller, 2003; Phinney & Kohatsu, 1997), and while it has not yet been established as a protective factor in CSA, it has been identified as playing an important role in one's experience of CSA and as being an important factor to investigate in relation to CSA (Fontes & Plummer, 2010; Kaiser, 2000).

A risk factor for experiencing trauma-related symptoms later in life is the severity of abuse experienced by the child (Kendall-Tackett, et al., 1993). Severity of abuse can be evaluated by examining factors such as the age of the child at the time of the abuse, the type of the abuse, and the number of occurrences of abuse (Zink, Kleges, Stevens, & Decker, 2009). Another risk factor for experiencing trauma-related symptoms is the presence of other traumatic experiences in the home in addition to CSA. One of these is exposure to domestic violence, which often co-occurs with child abuse and leads to trauma-related symptomatology (Dong, Anda, Dube, Giles, & Felitti, 2003).

The primary purpose of the present study was to use the theoretical conceptualization of traumagenic dynamics to examine the attitudes towards romantic relationships of female adolescent survivors of CSA and develop an empirically tested, clinical understanding of how CSA can affect the romantic relationships of teenage girls. The focus of this study is on females because the most recent National Incidence Study of Child Abuse and Neglect (NIS-4) reports girls to be at a disproportionately greater risk of CSA than males (Sedlak et al., 2010), with the results of the NIS-3 indicating they are three times more likely to be sexually abused than males (Sedlack & Broadhurst, 1996). Additionally, Dominguez et al., 2001 reported that girls are two times more at risk than boys for CSA during childhood and eight times more at risk during adolescence. This study also explored protective and risk factors related to survivors of CSA experiencing trauma-related symptoms later in life. The protective factors examined were ethnic

identity and social support, and the risk factors examined were the severity of the abuse and the presence of another traumatic event in the child's upbringing – specifically, domestic violence.

Background of the Problem

History of CSA Research

Some of the earliest findings on the existence of child sexual abuse occurred in the mid-1800s, when Ambroise Tardieu (1857, as cited in Labbe, 2004) analyzed 632 cases of sexual abuse in females and 302 cases of sexual abuse in males and documented the physical signs that were related to the severity of the abuse. In another study, he reported that from 1858 to 1869, of 11,576 cases of indecent assault and rape he investigated, 79% of the victims were children (Baartman, 1998). Unfortunately, during this time, children's accusations of abuse were not believed since they were not perceived as having rights; it took another century before child abuse was widely recognized (Labbe, 2004).

In early examinations of child sexual abuse, the phenomenon was often viewed as being fantasy (Freud, 1898/1962), or if it was accepted to have occurred, the traumatic impact of the abuse was minimized (Pilkington & Kremer, 1995). For instance, Freud's seduction theory (1896) posited that repressed memories of CSA were the only causes of hysteria. However, after concluding that the treatment he provided was ineffective and that CSA had a lower frequency than hysteria, and therefore could not be the only etiological factor, he posited that the unconscious cannot distinguish reality from fantasy, that the patients on whom he had based his theory had misled him into believing their fantasies of abuse, and he abandoned his theory regarding hysteria. This led to many professionals then conceptualizing all reports of CSA as being fantasy (McCullough, 2001). In the early 1900s, William Stern claimed that unfounded statements made by children were more likely than credible statement, and Tardieu's successor, Paul Brouardel, believed that since the men accused of sexually abusing children were viewed as

honorable, the accusation of abuse should be doubted (Baartman, 1998). Not only did this belief prevail throughout the world for some time, but even today the credibility of children's testimony and their accounts of their abuse experiences continue to be examined and questioned (Merryfield, 2001).

Even more upsetting than doubting children's accusations, Bender and Blau (1937) claimed that children often are to blame for the abuse, stating that in the cases they had seen, the child cooperated with the abuser to some extent, and in other cases, the child even assumed an active role in initiating the sexual abuse (Baartman, 1998). Even in the late 20th century, child victims continued to be blamed: in 1982, a judge ruled that a five-year-old girl who was abused by a 24-year-old man was "unusually promiscuous" and that the man "did not know how to resist her advances" (Baartman, 1998). Even recent research has blamed adolescent victims of sexual abuse, and perceived them as more responsible for their abuse and victimization than younger children (Merryfield, 2001). These claims can have dire consequences, most notably, with the adolescent receiving less support from non-offending caretakers, which can in turn result in greater symptoms of trauma (Collings & Payne, 1991; Feiring, Taska, & Lewis, 1998).

In the late 1930s, psychiatrists began to label child sexual abuse as sexual psychopathy, and urged society to view perpetrators and victims as mentally disordered individuals (Haugaard & Reppucci, 1988). Interest in evaluating perpetrator characteristics continued over time, as can be seen in Finkelhor's (1979) study examining the social role of the offender in their family, friendships, and community. At times, this focus on the behavior of the abuser was at the expense of considering the effects of sexual abuse on the child victim, thereby leading to the survivors of the abuse being studied as just a symptom of the offender's psychopathy. This emphasis created an interest in identifying the traits that made certain children vulnerable to

becoming victimized instead of identifying how the victimization affected them (Merryfield, 2001). Although this focus did view sexual abuse as being a traumatic occurrence, it still neglected to address the actual consequences of being sexually victimized.

It was not until the 1960s, when studies referred to child sexual abuse as indecent assault, rape, or incestuous relations, that child maltreatment began to be recognized in the American medical literature (Helfer & Kempe, 1974). And, it was not until the 1970s that the label of “child sexual abuse” became widely acknowledged (Merryfield, 2001). Since then, greater attention has been given to evaluating the prevalence and impact of the experience of sexual abuse as a child, with the 1980s seeing a shift towards viewing child sexual abuse as a traumatizing event for the child.

Until 1985, the majority of the literature examining the impact of CSA consisted of retrospective studies with adults (Kendall-Tackett, et al., 1993). For example, one of the most widely cited review pieces on the subject (Browne & Finkelhor, 1986) was based on 23 studies of adults and only four studies with children. Since 1985, there has been a significant increase in the number of studies concentrating specifically on children who have been sexually abused (Kendall-Tackett et al., 1993). These studies are imperative because they are relevant to establishing interventions and treatment with children, and allow for a greater understanding of how children process trauma (Kendall-Tackett et al., 1993).

While these studies have accomplished the task of exploring the traumatic impact of the abusive acts and the contribution of familial and environmental conditions, there has been a lack of substantiation regarding a theoretical explanation of the range of symptoms, the lack of a predominant symptom, and the fact that many survivors manifest no symptomatology (Kendall-Tackett et al., 1993). Additionally, the theoretical models that have been examined have focused,

to a much greater extent, on adults than on children (e.g., Edwards, 1997; LeClair, 1993; Ramirez, 2009), and virtually none of the studies examine interpersonal functioning in children while viewing CSA through a theoretical lens (DiLillo, 2001).

It is important for empirical studies on CSA to be completed with children so that the impact of the trauma on them can be understood; however, it is also important that studies examining theoretical models of the symptoms children are or are not manifesting be completed. A theoretical understanding can help individuals who constitute children's support systems to understand the behaviors they observe in these children and may also help in developing preventative measures that can help children positively cope with the trauma of CSA.

Effects of CSA

CSA is a problem that we must be aware of and take steps to prevent and treat, as there are both short-term and long-term effects that can result from it. Although no one symptom or general domain of symptomatology has been found to characterize survivors of CSA, a constellation of short-term and long-term symptoms has been observed (Kendall-Tackett et al., 1993), as the stress that results from this trauma can alter development and cause physiological, neurodevelopmental, emotional, behavioral, cognitive, and social impairment (Palmer, Farrar, & Ghahary, 2002). Short-term effects of CSA include behavioral, emotional, and health related symptoms. These include symptoms of Post Traumatic Stress Disorder (PTSD), the development of sexualized behavior, depression, anxiety, promiscuity, general behavior problems, poor self-esteem, disruptive behavior disorders, fear, anger, aggression, withdrawn behavior, inhibition, overcontrol, undercontrol, and antisocial behaviors (Dominguez, et al., 2001; Finkelhor, 1990; Kendall-Tackett et al., 1993; Walsh, Galea, & Koenen, 2012). Long-term effects include maladaptive sexual behavior, sexual dysfunction, damaged sense of self, self-destructive and

suicidal behaviors, substance abuse, feelings of isolation and stigma, difficulty in trusting others, a tendency toward revictimization, increased rates of psychopathology including anxiety, major depression, borderline personality disorder, somatization disorder, substance abuse disorders, PTSD, Dissociative Identity Disorder, bulimia nervosa, neurocognitive deficiencies, and neurobiological alterations (Beitchman et al., 1992; 1991; Briere & Runtz, 1990; Dominguez, et al., 2001; Ernst, Anst, & Foldenyi, 1993; Ferguson, Horwood, & Lynskey, 1996; Finkelhor, 1990; Mullen, Martin, Anderson, & Herbison, 1994; Mullen, et al., 1996; Palmer, et al., 1999; Perry, Conroy, & Ravitz, 1991; Polusny & Follette, 1995; Putnam, 2003; Reiker & Carmen, 1986; Usher & Dewberry, 1995; Walsh, et al., 2012).

In response to public policy needs, the emphasis on CSA research prior to 1985 was focused primarily on demonstrating the seriousness and severity of the impact of CSA. As research findings consistently suggested the seriousness of this problem, more consideration began to focus on those children who emerge from CSA who do not exhibit psychological symptomatology. Although CSA has a vast range of psychological and behavioral consequences, it has also been found that a substantial percentage of CSA survivors (21-49%) are asymptomatic, and most studies on the impact of CSA have routinely found a group of CSA survivors with little to no short-term or long-term symptomatology (Dominguez, et al., 2001; Finkelhor, 1990). There are numerous hypotheses that have been suggested as reasons for asymptomatic CSA survivors. These hypotheses include inadequate measurement, denial or underreporting of symptoms, delay in symptom development, having experienced less frequent abuse, a shorter duration of abuse, abuse that did not include penetration or force, and resilient characteristics possessed by the survivor (Beitchman et al., 1992; Dominguez et al., 2001; Finkelhor, 1990; Kendall-Tackett et al., 1993). In addition, it has been hypothesized that

asymptomatic presentation may be a result of the presence of a supportive relationship with an adult, parent, or sibling, lower parent distress, greater family cohesiveness, higher self-esteem, positive coping methods that do not include avoidance, developmental level, and the abuser not being a parent, all of which are mitigating factors that can serve as positive buffers for CSA survivors (Dominguez et al., 2001; Finkelhor, 1990; Kendall-Tackett et al., 1993).

Incidence and Prevalence

CSA occurs across all ethnic, racial, socioeconomic, and religious groups (Dominguez, Nelke, & Perry, 2001), and has been found to exist throughout history in all cultures and societies (MacMillan, 1998; Pereda, Guilera, Forns, & Gomez-Benito, 2009). While there have not been a great number of epidemiological studies on CSA in the last decade, and those that have been completed present conflicting results regarding the specific statistics of CSA (Pereda, et al., 2009), the results have all shown that CSA is a widespread problem and that even the lowest numbers indicate that a large number of individuals are survivors of CSA (Pereda et al., 2009; Edgardh & Ormstad, 2000). Prior to the 1970s, CSA was believed to be a rare occurrence; however, by the 1980s, the incidence of CSA increased dramatically (Finkelhor, 1978, Putnam, 2003). This increase was most likely a reflection of the greater awareness of CSA among professionals and the public, yet there are studies that suggest the overall incidence of CSA actually increased (Putnam, 2003).

Every year, more than three million reports of child abuse are made in the United States, and 9.3% of these reports are related to CSA (United States Government Accountability Office, 2011; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2013). However, it is important to keep in mind that incidence of CSA is inevitably underestimated when it is

measured due to factors such as secrecy, shame, criminal penalties the abuser may be subject to, and the young age of the victims (Goldman & Padayachi, 2000; Pereda, 2009; Widom & Morros, 1997). Estimates of the prevalence of CSA range widely. Nationally, estimates of lifetime CSA range from a low of 3% (Finkelhor & Dziuba-Leatherman, 1994) and a high of 40% (Bolen & Scannapieco, 1999) of adults who have experienced CSA, and internationally, estimates range from 2% to 62% (Andrews, Corry, Slade, Isakidis, & Swwanston, 2004). The variation is possibly due in part to the method of inquiry, selection and response rate, and the definitions of CSA that are used (studies differ as to what acts constitute CSA), and they differ on defining sexual abuse perpetrators as only adults or also including older children as perpetrators, thereby affecting the numbers that are reported.

Protective and Risk Factors in CSA

All children who experience CSA do not grow up to experience further abuse or symptoms of trauma as adults, accordingly, one criticism of many of the theoretical models that have been proposed to explain the effect of CSA is that they do not account for individual differences among survivors (Morrisette, 1999). Therefore, in addition to gaining an understanding of the consequences of CSA, it also important to gain an understanding of how the individual differences of CSA survivors can serve as risk and protective factors to experiencing or not experiencing symptoms of trauma later in life. Protective factors and resilience can be confused for one another. Protective factors differ from resilience in that resilience refers to one's response during times of adversity and protective factors refer to factors that are always present and functioning (Beauvis & Oetting, 1999). Protective factors are the personal resources and social context factors that increase the possibility of an adaptive outcome (Aguilar-Cafaie, Roshani, Hassanabadi, & Afruz, 2011; Beauvis & Oetting, 1999). In this study, the protective

factors examined were one's perception of social support received from her family and her ethnic identity status. The risk factors examined were the severity of abuse experienced (referred to as trauma severity) and experiencing domestic violence in one's home.

A positive perception of social support is associated with fewer psychological, behavioral, and emotional difficulties in survivors of CSA (Tremblay et al., 1999; Vranceanu et al., 2007). Positive ethnic identity is associated with psychological well-being (Phinney & Ong, 2007) and resilience in general adolescent populations, as well as some adolescent populations that have experienced trauma (Hackett, et al., 1992; Holleran & Waller, 2003; Phinney & Kohatsu, 1997).

Trauma severity is related to psychological maladjustment and has been conceptualized by such factors as a subject's age at first sexual abuse, number of perpetrators, coercion that was experienced, most severe abuse that was experienced, and number of occurrences of abuse (Fortier et al., 2009; Kendall-Tackett et al., 1993; Putnam, 2003). Traumas such as domestic violence frequently co-occur with child abuse, and there can be an inter-relationship between the effects of these co-occurring traumas (Dong, et al., 2003). Additionally, adolescents who have been exposed to domestic violence are at higher risk for becoming involved in teen dating violence (Fantuzzo et al., 1991). Each of these variables will be thoroughly explored in the following chapter.

Conceptualizing CSA

There have been a variety of theoretical explanations as to the effects of CSA and trauma. Initially, researchers examined the impact of sexual abuse by viewing it through the framework of Post Traumatic Stress Disorder (PTSD; e.g., Eth & Pynoos, 1985; McLeer, Deblinger, Atkins, Foa, & Ralkphe, 1988; Morrisette, 1999). In addition to this, protective factors have been

examined (Figley, 1998, 2010a, 2010b), and psychodynamic (Horowitz, 1976; Mannar & Horowitz, 1988), information processing (Burgess, 1988), self-esteem (Bagley & Young, 1989), psychosocial (Green, Wilson, & Lindy, 1985), behavioral (Berliner & Wheeler, 1987), cognitive (Janoff-Bulman, 1985), and neuropsychological models have been used. Also, the model of complex trauma (Courtois, 2008) has been examined, and a model conceptualized specific to CSA, the traumagenic dynamics model (Finkelhor & Browne, 1986, 1988) has been proposed to understand why certain symptoms are displayed by CSA and trauma survivors. Each of these models is described below.

Post Traumatic Stress Disorder Model

PTSD is a diagnostic category that was first included in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980). It came into use largely due to the necessity for nomenclature to diagnose the adverse reactions experienced by combat troops returning from the Vietnam War, and derived from observations and conceptualizations of war trauma by earlier researchers (Courtois, 2008). It organizes the symptoms that are experienced as a result of the trauma as re-experiencing (e.g., dissociative reactions such as flashbacks, intrusive memories, nightmares, intense/prolonged distress to trauma reminders, marked physiological reactivity to trauma-related stimuli); avoidance (e.g., avoiding reminders of the event, avoiding trauma-related thoughts or feelings); negative cognitions and mood (e.g., inability to recall key features of the trauma, persistent negative beliefs and expectations about oneself or the world, persistent distorted blame of self or others for the trauma or its consequences, persistent negative trauma-related emotions, markedly diminished interest in significant activities, feeling alienated from others, constricted affect); and arousal (e.g., irritable/aggressive behavior, self-destructive/reckless behavior,

hypervigilance, exaggerated startle response, concentration problems; DSM-5, American Psychiatric Association, 2013). Although it was originally formulated to explain the response to combat (Kendall-Tackett & Marshall, 1998), the DSM-5 editorial team concluded that many events could be viewed as the trauma-causing stressor that results in PTSD, one of these events being childhood sexual abuse (American Psychiatric Association, 2013).

Finkelhor (1987, 1990) reported that some of the benefit of using a PTSD framework to understand sexual abuse was that it provides a clear label and description of the phenomenon that victims of CSA suffer from and provides a perspective that this phenomenon has an etiological core and is not simply a list of symptoms (Morrisette, 1999). Additionally, the diagnosis of PTSD normalizes the presenting problems and depathologizes the survivor (Dolan, 1991; Kirschner, Kirschner, & Rappaport, 1993). It also helps survivors make sense of their experience (Morrisette, 1999) and acknowledges that symptoms are predictable (Blume, 1990). This allows for those treating victims of CSA to identify behaviors that are important to address in therapy and provides a model for psychological treatment (Finkelhor, 1990).

However, the use of PTSD as a framework for examining CSA has a number of limitations. PTSD is not an exact fit for the reactions survivors of child abuse display, so much so that the majority of sexually abused children actually do not meet the diagnostic criteria for PTSD (Kiser, Heston, Milsap, & Pruitt, 1991). While isolated traumatic incidents tend to produce the behavioral and biological responses to reminders of the trauma that are captured by PTSD, the chronic maltreatment experienced by many survivors of CSA can have a pervasive effect on the child's overall development. Moreover, the PTSD diagnosis is not developmentally sensitive, nor does it adequately describe the effect of trauma on the child's development (Finkelhor 1987, 1990; van der Kolk, 2005). In addition to the symptoms associated with PTSD,

many abuse survivors also suffer from a variety of other psychological symptoms including depression, anxiety, despair, substance abuse, revictimization, problems with interpersonal and intimate relationships, and medical and somatic concerns (Briere & Elliott, 2003; Courtois, 2008; Kendall-Tackett et al., 1993; Putnam, 2003; van der Kolk, Roth, Pelcovitz, & Sunday, 2005). These problems have been categorized as comorbid conditions instead of elements of the post-traumatic adaptation, and have been found to be difficult to treat or have not been treated within PTSD-focused interventions (Courtois, 2008; van der Kolk, et al., 2005.)

The danger of relying on the PTSD framework then is that a child who does not display sufficient symptoms to warrant a PTSD diagnosis may be perceived as being less traumatized, and therefore does not receive the treatment she needs (Morrisette, 1999). In addition to difficulties with symptomatology, the conceptualization of PTSD does not consider the cognitive distortions around family relations, and sexual behavior that results from sexual abuse, and instead focuses only on the constriction of affect (Finkelhor, 1987). Finally, the PTSD diagnostic emphasis on the examination of pathology and symptoms may fail to acknowledge the survival capabilities or resiliency that is displayed by some CSA survivors, and instead focuses on the inevitability of the emotional and behavioral consequences that are displayed (Blume, 1990).

In response to the limitations the PTSD model poses, both in conceptualizing the effects of trauma generally and the effects of CSA specifically, researchers have developed other models to explain the etiology and symptomatology that is associated with the experience of trauma.

Traumatic Stress Injury Model

Figley (2010a) promotes a paradigm shift to a focus on Traumatic Stress Injury (TSI) instead of the focus on illness, disorder, and psychopathology that PTSD provides. He stresses that reactions to trauma and stress span from normal reactions to injuries and illnesses that

consist of specific syndromes with highly predictable symptoms and courses over time (Figley & Nash, 2007). He explains that conceptualizing the reactions to trauma as being on a spectrum allows for a focus on protective factors that can play a role in mitigating or even preventing acute and chronic trauma-related symptoms, and that this focus can lead to an expectancy of recovery, resilience, thriving, and even prosperity.

TSI refers to an extreme traumatic-related stress reaction. It can be manifested in four ways: a) A physical fatigue injury that is caused by the wear-and-tear of accumulated stress and treated by rest and relaxation; b) A grief injury that is caused by the loss of someone or something that is highly valued and dissipates with time and contemplation. c) A belief injury which results from a sense of contradiction between what one values and awareness of one's actions that violate these values; d) A trauma or stress injury that is caused by the impact of terror, horror, or helplessness that is distressing when recalled either consciously or unconsciously (Figley, 2010a).

An assumption of TSI is that these injuries are preventable and manageable and that those who are resilient and take advantage of self-care activities are better prepared to manage the trauma-causing event(s). Figley's (2010a) TSI Predictive Model more specifically explains who is likely to be vulnerable to one or more of the TSIs. This model posits that innate, trait-related resiliency factors, state resilience factors, trauma-related stress intensity, and acute trauma-related stress reactions are predictive of one's vulnerability to experiencing a TSI. Innate, trait-related factors are factors that exist over time and situations, and are used to adapt to various adversities. They include intelligence, trait resilience, stress adaptation competence, and self-confidence. State resilience factors are a measure of current functioning. They are the coping, functioning, and necessary resources that are used in a specific adversity. State resilience refers

to the ability to apply trait resilience factors in overcoming a specific trauma. Together, state and trait resilience contribute to the conscious and unconscious efforts to monitor one's psychological, emotional, spiritual, and physical needs, which together are referred to as self-care (Figley, 2010b). Self-care, in turn, predicts one's level of thriving, which is the degree to which one feels successful physically and psychosocially. Thriving can be high-level, which is associated with strength-based learning that applies and reinforces new knowledge in a way that enhances effective coping. Thriving can also be low-level, which is associated with fear-based learning that focuses primarily on reassurances (Figley, 2010b). Trauma-related stress intensity refers to the demands placed on a person as an individual, and in an environmental and/or familial context. Finally, acute trauma-related stress reactions refer to psychological, social, and behavioral reactions (Figley, 2010a). Through his Traumatic Stress Recovery Model, Figley (1998) explains that identifying and focusing on these resilience factors can promote positive outcomes and even prevent the conversion of traumatic stress to stress injury.

Psychodynamic, Information Processing, Psychosocial, and Developmental Models

Other theoretical models that have been explored in response to the limitations posed by the PTSD model of conceptualizing the effects of CSA include the psychodynamic, information processing, psychosocial, and developmental models. The psychodynamic model posits that the traumatic event must be assimilated and integrated into the existing schemata, and that an oscillation occurs between the intrusive experience state and the denial/numbing state (Horowitz, 1976; Mannar & Horowitz, 1988). The information processing model (Burgess, 1988) posits that the trauma one experiences produces anxiety that is dealt with through defensive coping operations such as disassociation, denial, and/or reenactment. The psychosocial model stresses that the survivor's personal characteristics play a role in her psychological outcome (Green et al., 1985).

The developmental model posits that the nature of the trauma and the way the trauma is manifested are dependent on one's developmental stage during the time of the trauma (Goodwin, 1984; Wilson, Smith, & Johnson, 1985), and that age-appropriate developmental tasks are disrupted by sexual stimulation, while legitimate developmental needs are unaddressed (Tharinger, 1990). While these models look at coping mechanisms and individual characteristics, and therefore provide foci for treatment, they also generalize the vulnerability of children, do not account for internal and external resources such as resiliency and support, and fail to address the varying degrees of symptomatology that occur (Morrisette, 2009). Additionally, the developmental model has a lack of acknowledgement of the individual differences that characterize children; because of this, those who fail to meet certain age-appropriate criteria may not be assessed or diagnosed accurately (Morrisette, 1999).

Behavioral and Cognitive Models

There are also behavioral and cognitive models that attempt to conceptualize CSA. The behavioral model examines operant and classical conditioning theories to explain the anxiety that is experienced in situations that are connected to the original abuse context (Berliner & Wheeler, 1987). The cognitive model focuses on assumptions held by the survivor that are affected by the abuse; which are: the realization of vulnerability; belief that the world is not just, orderly, and benign; and the belief the victim holds that she may not be decent and worthy (Janoff-Bulman, 1985). The cognitive behavioral model examines both cognitive and behavioral responses to abuse, paying attention to inaccurate beliefs, and modeled and reinforced behaviors (Morrisette, 1999). Although these models successfully explore the cognitions and behaviors of CSA survivors, they neglect to examine the strategies used by resilient children, the significance of other factors in the child's experience such as their developmental state, the relationship to the

perpetrator, the frequency/duration/intensity of the abuse, family dynamics, or emotional reactions (Morrisette, 1999).

Neurobiological Model

In addition to these models, body and brain reaction to trauma has also been examined in conceptualizing traumatic responses. Childhood abuse has been linked to changes in brain structure, brain function, and stress-responsive neurobiological systems (Anda et al., 2006; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Walsh, et al., 2012. Palmer et al. (1999) and, Perry (2009) explain that child maltreatment can disrupt brain development and that when a child experiences abuse, there can be disruptions to neurodevelopment, which can lead to compromised functioning. The adverse experience interferes with normal patterns of neurodevelopment by creating abnormal and extreme patterns of neural and neurohormonal activity. When a child is threatened, the stress-response neural networks of the brain become activated in a prolonged and repetitive manner. This causes the brain to “reset” and act as if the child were under persistent threat (Perry, 2009). This activation can affect the development of the brain by altering neurogenesis, migration, synaptogenesis, and neurochemical differentiation (Perry, 2001), causing the brain to change in a “use-dependent” fashion. This means that the more threat-related neural systems are activated during development, the more they will become permanently present (Perry, 2001). When a child perceives a threat, his or her brain mobilizes to adapt to it, causing emotional, behavioral, cognitive, social, and psychological functioning to change (Perry, 2001). The specific symptoms that a child develops will be related to the intensity and duration of the adaptive response to the threat. If the response is activated long enough, molecular, structural, and functional changes occur in those brain systems, increasing the likelihood of long-term symptoms (Perry, 2001). For example, if a child responds with

hyperarousal, the child will be vulnerable to developing hyperarousal related symptoms and disorders such as PTSD, and will experience persistent hyperarousal (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). The specific symptoms that a child develops can vary with the nature, frequency, pattern, and intensity of the abuse, the adaptive style of the child, and the presence of attenuating factors such as support systems (Perry, 2001). In studies examining the neurobiological impact of trauma in children and adolescents, a dysregulated, sensitized stress-response neurobiology has been found, providing evidence that the adaptive responses to threat become use-dependent, permanent traits (Perry, 2001). In order to counteract this, therapy seeks to change the brain by creating patterned, repetitive activation in the neural systems that mediate this dysfunction (Perry, 2009).

Structural and functional neurological changes have also been examined in relation to childhood abuse. These studies have found reduced hippocampus volume and increased initial activation in the amygdala, the region of the brain involved among those who have experienced child abuse (Walsh, et al., 2012). Additionally, epigenetic modifications have been examined in relation to child maltreatment. DNA methylation (the addition of a methyl group to the five position of the cytosine pyrimidine ring or the number six nitrogen of the adenine purine ring) has been most widely studied (Walsh, et al., 2012). Animal studies have revealed that increased DNA methylation in the hippocampus in those exposed to psychosocial stress and childhood trauma exposure, including CSA, has been associated with methylation in specific genes. This has been examined in relation to the adverse outcomes associated with childhood abuse. Research in this area is nascent; however, there have been indications that epigenic changes associated with exposure to stressors in the environment, such as CSA, may influence the development of adverse symptomatology (Walsh, et al., 2012).

Complex Trauma Model

Another trauma model that has begun to be investigated is the complex trauma model. This model recognizes that some forms of trauma are more pervasive and complicated than others (Courtois, 2008). In this recognition, trauma has been differentiated as “Type I” single-incident trauma and “Type II” complex or repetitive trauma (Terr, 1991). Type I trauma is an event that occurs unexpectedly such as an accident, natural disaster, or single episode of abuse or assault, and Type II trauma refers incidents such as ongoing abuse, domestic violence, community violence, war or genocide. Type II traumas often occur in combination or cumulatively, and because they are often perpetrated by someone known to the victim, they usually involve a fundamental betrayal or trust in primary relationships (Ford & Courtois, 2009). In addition to Type II trauma being associated with a much higher risk for development of PTSD than Type I trauma, it can also alter a person’s psychobiological and socioemotional development when it occurs during the critical developmental periods of a child (Ford & Courtois, 2009). Type II trauma is also referred to as complex trauma.

Courtois (2008) defined complex trauma as “a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts” (p.86) and van der Kolk (2005) and explained that it describes “the experience of multiple, chronic and prolonged, developmentally adverse traumatic events most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early life-onset” (p.402). He went on to explain that in the case of child abuse, the development of the child can be seriously compromised by repetitive abuse and inadequate response at the hands of those whom she relies on for protection and safety. Complex trauma is associated with seven primary domains of impairment: attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, and self-concept (van der

Kolk, et al., 2005). The timing of the occurrence of complex trauma, specifically CSA, is often during the critical developmental periods of childhood when a child's self-definition and self-regulation are being formed. Since the trauma frequently results in the disruption or distortion of a child's sense of security and trust in core relationships during this critical time, it is a violation of, and challenge to, the development of the child (Ford & Courtois, 2009).

The concept of complex trauma arose in response to the use of PTSD as a conceptualization of Type II trauma. Through the use of factor analytic studies of child abuse trauma, the effects of this type of trauma were found to differ significantly from PTSD even though they are of a posttraumatic nature (Herman, 1992). To better understand and conceptualize the reaction to complex trauma, the concepts of complex PTSD (CPTSD) and Disorders of Extreme Stress Not Otherwise Specified (DESNOS; Pelcovitz et al., 1997) were proposed. The Complex Trauma taskforce of the National Child Traumatic Stress Network (NCTSN) has now also extended DESNOS to describe the complex trauma reaction displayed by children by advancing a new diagnosis, Developmental Trauma Disorder (DTD; Ford & Courtois, 2009; van der Kolk, 2005). DTD varies from DESNOS in that it includes behavioral and relational problems that are more common in childhood than in adulthood (Ford & Courtois, 2008). DTD has been proposed in order to capture the wide range of symptoms common in victimized children, which often generate multiple comorbid diagnoses. This diagnostic system can result in treatments that do not comprehensively address the spectrum of problems and therefore reduce the likelihood of positive treatment outcomes (D'andrea et al., 2012). In a 1991 and 1992 multisite field trial that completed to investigate PTSD and alternative diagnoses, the PTSD committee for the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994) found that CPTSD has high construct validity as it

is specific to trauma and rarely found among non-trauma exposed individuals, and is distinct from but comorbid with the PTSD diagnosis (Roth, Pelcovitz, Van Der Kolk, & Mandel, 1997).

Follow-up studies found support for the belief that child abuse predicts a higher risk for developing CPTSD or DESNOS (Roth et al., 1997). The diagnostic conceptualization for CPTSD/DESNOS as defined by the 1991-1992 field trial consisted of seven problem areas:

(a) Alterations in the regulation of affective impulses; (b) Alterations in attention and consciousness, such as the presence of dissociative responses; (c) Alterations in self-perception, such as a sense of guilt and responsibility; (d) Alterations in perception of the perpetrator; (e) Alterations in relationships to others, such as not being able to trust or feel intimate with others; (f) Somatization and/or medical problems; (g) Alterations in systems of meaning, such as feelings of hopelessness and despair (van der Kolk et al., 2005).

DTD's two primary features are: (a) dysregulation in the domains of emotion, cognition, somatic functioning, relationships, behavior, and/or self-attribution in response to a stressor; (b) altered beliefs in response to abandonment, betrayal, and/or victimization (Ford, Hartman, Hawke, & Chapman, 2008). When clinicians were questioned about the utility of DTD, Ford et al. (2013) found that clinicians viewed DTD as comparable in clinical utility to PTSD and that the symptoms of DTD are discriminable and not fully accounted by other disorders. Although support for the concepts of CPTSD/DESNOS/DTD has been growing, there has not been much empirical examination of them. Wamser-Nanney and Vandenberg (2013) completed one of the first studies examining the concept of complex trauma in a child population and found that child survivors of complex trauma presented with higher levels of generalized behavior problems and trauma-related symptoms when compared to those who had experienced other types of trauma or interpersonal trauma that began later in life, providing support for a complex trauma diagnostic

construct for children and adolescents. The strength of the CPTSD/DESNOS/DTD diagnoses is that they examine the reactions to complex trauma. In defining complex trauma, these diagnoses focus on the recurrence of trauma as central to its conceptualization; however, not all CSA survivors experience reoccurring trauma. Additionally, CPTSD/DESNOS/DTD are not specific to CSA.

Traumagenic Dynamics Model

A model specific to CSA was conceptualized prior to the emergence of these proposed diagnoses. The traumagenic dynamics model was theorized by Finkelhor and Browne (1985, 1988) as a response to the limitations of applying the PTSD model to sexual abuse. This is a comprehensive model specific to CSA that posits that the experience of CSA can have different effects based on the variety of dynamics that account for the different symptoms displayed by CSA survivors. The traumagenic dynamic model views the trauma of CSA as resulting not just from the abuse but also from the conditioning processes that exist before and after it, with the effects of the abuse depending on the character of the abuse and on four main areas of development: (a) Sexuality (traumatic sexualization); (b) The ability to trust in personal relationships (betrayal); (c) Sense of ability to affect the world (powerlessness); (d) Self-esteem (Stigmatization/Self-blame). Since the traumagenic dynamics model is specific to sexual abuse, it provides for a more comprehensive view of the resulting traumatization than viewing the trauma through the lens of PTSD.

Due to the comprehensiveness of the traumagenic dynamics model, its ability to take into account individual differences of CSA survivors, and its ability to examine dynamics that may contribute to the traumatic symptoms being exhibited, the traumagenic dynamics model was used in the present study to conceptualize the effects of CSA. It will be examined more thoroughly in the next chapter.

Effect of CSA on Romantic Relationships

A large amount of research examining the impact of CSA has focused on intrapersonal difficulties that arise (DiLillo, 2001). These short-term and long-term traumatic effects of CSA are reviewed above. Of specific interest in the present study is the finding that interpersonal functioning can also be significantly affected by CSA (DiLillo, 2001). Interpersonal relationships include romantic relationships, friendships, and relationships with family. In all these realms of intimate relationships, it has been found that survivors of CSA are not as well-adjusted in the social realm as their non-abused peers (Friedrich, Urquiza, & Beike, 1986; Harter, Alexander, & Neimeyer, 1988; Jackson, Calhoun, Amick, Maddever, and Habif, 1990).

The present study explored the attitudes adolescent girls who are survivors of CSA have towards romantic relationships. The attitudes adolescents hold towards dating are related to the occurrence of sexual, psychological, and physical violence within their romantic relationships (Bookwala, Frieze, Smith, & Ryan, 1992; Check & Malamuth, 1985; McDonell, Ott, and Mitchell, 2010; Price, Byers, & The Dating Violence Research Team, 1999). Adolescent dating violence has been found to be related to relationship violence in adulthood (O'Leary, Malone, & Tyree, 1994; Wolfe, et al., 2004); therefore, understanding the attitudes that adolescents have toward romantic relationships is critical. Additionally, in adulthood, pervasive patterns of distress have been described to be present in the relationships of women with a history of CSA (DiLillo, 2001), and CSA has been found to be a predictor of dissatisfaction with intimate partner relations (Courtois, 1979; DiLillo & Long, 1999; Jehu, 1988). Since there is continuity between relationship patterns in childhood and adulthood, it stands to reason that the continuity between childhood and adolescence should be even greater as there is less of an opportunity to modify one's relationship patterns by adolescence (Hazaan & Shaver, 1987). This suggests the

interpersonal effects of CSA are likely to affect adolescent functioning in a romantic relationship just as they do in adults. For these reasons, understanding the relationship between CSA and adolescents' attitudes towards relationship is important because it may provide an earlier point of intervention against girls and women becoming involved in unhealthy relationships.

Statement of the Problem

CSA is associated with a range of short-term and long-term emotional, behavioral, cognitive, and health-related effects (Kendall-Tackett, et al., 1993). One of these long-term effects is relationship-based difficulty (Bank & Burrason, 2001; Coid, et al., 2001; DiLillo, 2001; Wolfe, et al., 2004). While there is much literature that examines the relationship between CSA and adult romantic relationships (Briere, 1996, Jehu, 1988, Courtois, 1979, DiLillo & Long, 1999; DiLillo, 2001), the relationship between CSA and adolescent relationships has not been examined as thoroughly (e.g., Wolfe, et al., 2004). Since there is a relationship between adolescent attitudes toward dating and the occurrence of dating abuse, and since it is already known that CSA is related to abuse in adult romantic relationships, it is clear that the relationship between CSA and adolescent dating attitudes needs to be explored (Bookwala, et al., 1992; Check & Malamuth, 1985; McDonell, et al., 2010; Price, et al., 1999). The results of these explorations will facilitate the development of prevention and targeted intervention programs.

In order to adequately understand this relationship, this study was grounded in the traumagenic dynamics theory (Finkelhor & Browne, 1986, 1988). This model evaluates the effects of abuse on four dimensions: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame. These provide potential points of clinical intervention. Although this theory has been examined with adult survivors of CSA, its examination with adolescent samples remains scarce, as does an examination of how protective and risk factors relate to the

presence of traumagenic dynamics dimensions. Examining how this theory operates with adolescent CSA survivors will allow for empirically based clinical interventions targeted to the specific symptoms that are exhibited. In this vein, understanding how protective and risk factors contribute to the functioning of female adolescent CSA survivors allows for further insight into targets for intervention and/or prevention for these adolescents.

Research Questions

The following questions that were examined in the present study:

1. What is the relationship between overall traumagenic dynamics symptomatology and attitudes toward romantic relationships in adolescents who have experienced CSA, and what is the relationship between each specific traumagenic dynamic symptom:
 - (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame and attitudes toward romantic relationships in adolescents who have experienced CSA?
2. Does past or present exposure to domestic violence serve as a risk factor for traumagenic dynamic symptomatology in adolescent females who have experienced CSA?
3. Does greater trauma severity serve as a risk factor for experiencing greater traumagenic dynamic symptomatology in adolescent females who have experienced CSA?
4. Does greater trauma severity serve as a risk factor for endorsing more unhealthy attitudes toward romantic relationships by adolescent females who have experienced CSA?
5. What is the relationship between perception of family support and sense of ethnic identity in adolescent females who have experienced CSA?
6. For adolescent females who have experienced CSA in the presence of increasing trauma severity, do perceived social support and a sense of ethnic identity serve as protective factors against the presence of traumagenic dynamic symptomatology over and above therapy?

7. For adolescent females who have experienced CSA in the presence of increasing trauma severity, do perceived social support and a sense of ethnic identity serve as protective factors against the endorsement of unhealthy attitudes over and above therapy?

Operational Definitions

This section will provide definitions of each variable of interest. Descriptions, reliability and validity information for each of the variables' associated measures are reported in Chapter III.

Attitudes toward Romantic Relationships

Attitudes toward romantic relationships refers to the participant endorsing an acceptance of physical, sexual, emotional, or psychological aggression in romantic relationships (Price, et al., 1999; Feiring, Deblinger, Hoch-Espada, & Haworth, 2002).

A healthy attitude toward romantic relationships refers to not endorsing an acceptance of physical, sexual, emotional, or psychological aggression in a romantic relationship. An unhealthy attitude toward romantic relationships refers to endorsing an acceptance of physical, sexual, emotional, or psychological aggression in a romantic relationship.

Attitudes toward romantic relationships were assessed using The Intimate Partner Violence Attitude Scale-Revised (IPVAS-R; Fincham, Braithwaite, & Palsey 2008; see appendix G). A description of this measure is provided in the following chapter.

Child Sexual Abuse

Definitions of child sexual abuse vary, and researchers do not have a consensus on its definition (Haugaard, 2000; Hulme, 2004). They frequently include descriptions of the sexual activity, age at onset of abuse, age difference between victim and abuser, and whether force was used (Hulme, 2004). For purposes of this study, Dominguez, et al.'s (2001) inclusive definition of child sexual abuse was adopted, so that it was defined as any sexual activity involving a child

where consent is not or cannot be given. In the present study, the presence of a history of CSA and the severity of the CSA were assessed using the Sexual Abuse Severity Score (Zink et al., 2009; see appendix J). A description of this measure is provided in the following chapter.

Domestic Violence

Domestic violence is pattern of abusive behaviors including a wide range of physical, sexual and psychological maltreatment used by one person in an intimate relationship against another to gain power unfairly or maintain that person's misuse of power, control and authority (American Psychological Association, 1996). In the present study, study participants' past or present exposure to domestic violence was assessed by having the researcher answer two questions at the end of the Sexual Abuse Severity Score (Zink et al., 2009) that asked if the participant's clinical chart indicated past or present exposure to domestic violence (see appendix J).

Ethnic Identity

Ethnicity refers to a group that is socially defined on the basis of a shared culture (Cornell & Hartmann, 2007). Ethnic identity refers to the sense one feels of belonging to his or her ethnic group, and the part of one's thinking, perceptions, feelings and behavior that is due to group membership (Rotherham & Phinney, 1987). In the present study, ethnic identity was assessed using the Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007; see appendix I). A description of this measure is provided in the following chapter.

Protective Factor

Protective factors are the personal resources and social-contextual factors that are functioning at all times to increase the possibility of adaptive outcomes (Aguilar-Cafaie, et al., 2011; Beauvis & Oetting, 1999). In the present study, the perception of family support and sense of ethnic identity were hypothesized to serve as protective factors. They were determined to be

protective factors if they did not predict traumagenic dynamic symptomatology and/or the endorsement of unhealthy attitudes toward romantic relationships in adolescent females who had experienced CSA.

Perception of Family Support

Family support refers to a family member(s) who provide information to an individual leading him or her to believe that he or she is cared for, loved, esteemed, and valued (Cobb, 1976; p. 300). In the present study, perception of family support was assessed using the Family Subscale of the Social Support Appraisals Scale of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989; see appendix H). A description of this measure is provided in the following chapter.

Risk Factor

Risk factors are personal or environmental characteristics that are associated with an increased probability of maladaptive outcomes (Compas, Hinden, & Gerhardt, 1995). In the present study, trauma severity and study participants' past or present exposure to domestic violence were hypothesized to serve as factors. They were determined to be risk factors if they predicted traumagenic dynamic symptomatology and/or the endorsement of unhealthy attitudes toward romantic relationships in adolescent females who had experienced CSA.

Trauma Severity

The definition of trauma severity has been fairly informal and intuitively based (Chaffin et al., 1997; Kendall-Tackett, et al., 1993). In order to empirically measure severity, the Sexual Abuse Severity Score (Zink et al., 2009; see appendix J) was used in the present study. This scale associates greater trauma severity with younger age at first sexual abuse, greater number of perpetrators, greater coercion, more severe abuse (e.g., sexual intercourse is a more severe abuse

than a perpetrator exposing himself), and a greater number of occurrences of abuse. A more detailed description of this measure is provided in the following chapter.

Traumagenic Dynamics

Traumagenic dynamics refer to the four factors proposed to result from CSA by the traumagenic dynamic theory (Finkelhor & Browne, 1986; 1988). The four dynamics are: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame. The presence of these dynamics will be assessed by the Trauma-Related Beliefs Questionnaire (TRB; Hazzard, 1993; see appendix F), an instrument that is related directly to the traumagenic dynamic theory in that each subscale corresponds to a traumagenic dynamic. A description of this measure is provided in the following chapter.

Significance of the Study

This study used the theory of traumagenic dynamics to examine how symptomatology resulting from CSA is related to the attitudes adolescent females have towards interpersonal relationships. In examining this relationship, social support and ethnic identity were examined as protective factors against the endorsement of unhealthy attitudes towards romantic relationships, and trauma severity and domestic violence were examined as risk factors for the endorsement of unhealthy attitudes towards romantic relationships.

This study aimed to provide a theoretical understanding of how CSA and attitudes toward romantic relationships are related, as well as an understanding of the protective factors that aid in children who have experienced CSA exhibiting decreased symptomatology. It is hoped that with this knowledge, individuals who work with survivors of CSA can gain a more comprehensive understanding of children's reactions to abuse, which can aid in determining preventative measures that can help them positively cope with the trauma of CSA.

CHAPTER II

Literature Review

Child sexual abuse (CSA) can have a range of psychological, behavioral, cognitive, and interpersonal effects on its survivors. These effects can be mediated by a number of factors that include personal, family, environmental, cultural, and abuse-related characteristics. This study examined the effect of CSA on adolescent females' attitudes towards romantic relationships and the intervening factors of family support, ethnic identity, and trauma severity. While Chapter I provided an overview of theoretical conceptualizations for CSA, this chapter will explore in detail the traumagenic dynamic theory of CSA. This chapter will also review the relationship between CSA and the attitudes adolescent female survivors of CSA have towards romantic relationships. In addition, literature explaining the role of risk and protective factors in how CSA affects survivors will be presented. Finally, the protective factors of perception of family support and sense of ethnic identity and the risk factors of trauma severity and exposure to domestic violence will be explored both generally and in relation to survivors of CSA.

The Traumagenic Dynamic Model of CSA

The traumagenic dynamic model of child sexual abuse was conceptualized by Finkelhor and Browne in 1985 to create a systematic understanding of the effects of CSA. This model examines the effect(s) of CSA on individuals who have experienced both single and multiple incidents of CSA (as opposed to the complex trauma model, which is focused on the experience of multiple incidents of trauma). Traditionally, the literature on CSA consisted of observations of the problems associated with a CSA history without any clear model specifying how or why CSA results in these problems (Finkelhor & Browne, 1986). Then, when researchers became

aware of the trauma that impacts CSA survivors, this trauma was conceptualized through the use of PTSD diagnostic criteria (Merryfield, 2001).

However, there are a number of limitations of using the PTSD diagnostic criteria (per the DSM-5 American Psychiatric Association, 2013) to understand the effects of CSA. First, research that has examined the PTSD framework focuses only on the impact on the individual and neglects examining the interaction of the system the child is a part of, even though other research has suggested that family variables such as attachment and support can serve to moderate the effects of sexual abuse on the child's symptomatology (Friedrich, Leucke, Belike, & Place, 1992). Second, PTSD symptoms are not present in all individuals who have experienced CSA (Finkelhor and Browne, 1985, 1988). The danger then of using the PTSD conceptualization is that children who do not show these specific, outward symptoms may be in danger of being dismissed and not receiving the treatment they need (Merryfield, 2001). Third, using the PTSD framework can lead to a concentration on the trauma instead of on the survivor or the impact of the victimization she experienced. In doing this, the risk and protective factors the survivor possesses may be overlooked (Finkelhor & Kendall-Tackett, 1997).

In order to synthesize the various experiences of CSA, including those not related to PTSD symptomatology, Finkelhor and Browne (1985) developed the traumagenic dynamics model. This is an integrated model of trauma that utilizes a conceptual framework to guide the study of CSA (Finkelhor & Browne, 1985, 1988). The traumagenic dynamics model encompasses the PTSD perspective and also includes the symptomatology that is beyond the boundaries of the PTSD diagnostic criteria. It examines the multilateral impact of CSA and goes beyond just exploring the degree of trauma suffered to also addressing the array of trauma that has occurred (Merryfield, 2001). The model postulates that the experience of CSA can be

analyzed in terms of four trauma-causing factors, which are referred to as traumagenic dynamics. These are as follow: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame. Each of these dynamics can lead to different trauma-related reactions and allow for CSA to be examined not just as an event, but as a process of extended traumatization in which different portions of the process contribute to different dynamics (Finkelhor, 1987). The resulting dynamics are beliefs and ideas about the world that result from CSA and guide the child's emotions and behaviors (Ramirez, 2009). Although these dynamics can occur with other types of trauma (e.g., combat trauma, interpersonal violence) and are not necessarily unique to CSA, the amalgamation of the four dynamics in one circumstance makes the trauma of CSA unique when compared to other traumas (Finkelhor & Browne, 1985).

Traumatic Sexualization

The first dynamic, traumatic sexualization, refers to the process in which, as a result of the CSA, a child's sexual feelings and attitudes are shaped in an interpersonally dysfunctional manner (Finkelhor & Browne, 1985). These feelings and attitudes can result in a child displaying inappropriate sexual behaviors, experiencing confusion and misconception about her sexual self-concept, and having unusual emotional associations to sexual activities (Finkelhor & Browne, 1985). Empirical examination of the effects of traumatic sexualization have found that this dynamic is associated with a greater number of sexual partners in adulthood (Senn, et al., 2012) and has a negative effect on self-esteem, particularly in relation to social and sexual relationships (Cantón-Cortés, et al., 2013.) Finkelhor and Browne (1985) postulate that over the course of the abuse, this dynamic can develop in a variety of ways. This dynamic is seen when the perpetrator continuously uses the child for sexual behavior that is inappropriate to her level of development. It is also seen when the perpetrator offers affection, attention, privileges and gifts for sexual

behavior so that the child learns to use sexual behavior as a method for manipulating others to satisfy her needs. Additionally, this dynamic is produced when parts of the child's anatomy are given distorted importance and meaning, so as to be fetishized. It occurs when misconceptions and confusions about sexual behavior and sexual morality are transmitted from the perpetrator to the child. Finally, it can result when the child associates frightening memories and events with sexual activity. The degree of traumatic sexualization varies with sexual abuse experiences. Experiences in which the child is made to evoke a sexual response, enticed to participate, or victimized with brute force are all associated with a greater degree of traumatic sexualization. Additionally, when a child is at an age or developmental level at which she understands the sexual implications of what is taking place, as opposed to being at an earlier age or developmental level, she is likely to experience a greater degree of traumatic sexualization (Finkelhor & Browne, 1985). For this reason, the present study is examining the impact of CSA on adolescent girls as opposed to the impact on preschool or school aged girls.

Betrayal

The second traumagenic dynamic, betrayal, refers to the process in which a child who endured CSA realizes that someone on whom she was dependent, trusted, or loved has caused her harm (Finkelhor & Browne, 1985). Not only can the perpetrator of the CSA cause this harm, but so, too, can a non-abuser on whom the child was dependent. This non-abuser may be a trusted individual who was unable or unwilling to protect or believe the child or someone whom is trusted by the child who changes his or her attitude towards the child after the disclosure of the abuse. A child who, upon disclosure, is not believed, is blamed, or is ostracized will experience a greater sense of betrayal than a child who is supported (Finkelhor & Browne, 1985). Therefore, not only can the abuse lead to feelings of betrayal, so can the response to the disclosure by other trusted individuals in the child's life (Merryfield, 2001). It is believed that even if the child has secure

attachments, this experience can cause a sudden change in attachment to her primary figures and result in the distrust of others, an impaired ability to form close social or romantic relationships, discomfort in intimate relationships, feelings of depression, and decreased self-esteem, resulting in a vulnerability to subsequent abuse (Cantón-Cortés, et al., 2013; Friedrich, et al., 1992).

Powerlessness

The third traumagenic dynamic, powerlessness, refers to the process in which a child is rendered powerless and her will, desires, control, and sense of efficacy are recurrently disregarded (Finkelhor & Browne, 1985). Powerlessness can lead the child to assume that she has no control over her environment, and this feeling can lead to less positive outcomes than if she feels she does have such control (Edwards, 1997). It has been related to general psychological distress (Hazzard, et al., 1995; Kallstrom-Fucqua, et al., 2004), anxiety, depression (Cantón-Cortés, et al., 2013), somatization and disassociation (Finkelhor & Browne, 1985). A basic sense of powerlessness results from a child's body and territory being repeatedly invaded against her will. This dynamic is exacerbated by the coercion and manipulation the offender may use. If a child sees that her attempts to stop the abuse are ineffective, this dynamic can be further reinforced, as in a learned helplessness model. Finally, powerlessness is amplified if a child is not able to make other adults understand what is happening, if she feels fear, or if she begins to recognize how conditions of dependency have trapped her in the abusive situation (Finkelhor & Browne, 1985; 1988). The feelings of powerlessness can ultimately lead to an overall reduced sense of self-efficacy and a distorted view of the self (Freidrich, et al., 1992).

Stigmatization/Self-Blame

The fourth and final traumagenic dynamic, stigmatization/self-blame, refers to the negative connotations that are communicated to the child around the CSA experience and that become incorporated into her self-image (Finkelhor & Browne, 1985). Examples of these connotations are that she is bad and that she should feel shame and guilt. These implications may come from the abuser directly, such as when he blames or demeans the victim, or he may convey messages of shame by pressuring the victim to keep the abuse a secret, thereby reinforcing that she is different and has done something wrong. Additionally, stigmatization/self-blame may be reinforced when the child has a prior sense (many times from religious or cultural beliefs) that the abusive act is considered to be deviant or taboo, or if people react with shock or hysteria, or blame the victim after the abuse is disclosed. Finally, stigmatization/self-blame may also be seen when others ascribe negative characteristics to the child such as having loose morals as a result of the abuse (Finkelhor & Browne, 1985). This dynamic has been related to general psychological distress (Coffey, Leitenberg, Henning, Turner & Bennett 1996; Kallstrom-Fuqua, et al., 2004), sexual disorders, and dating aggression (Feiring, Simon, & Cleland, 2009). Stigmatization and self-blame can occur in various degrees. Children who are told clearly that they are not at fault, or who find out that many other children experience CSA may have some of their stigma diminished compared with children who are blamed, or children who are told nothing, left to make their own interpretations, or feel different and isolated. Younger children may not have awareness of social attitudes, and therefore may experience very little stigmatization (Finkelhor & Browne, 1985; 1988), meaning that adolescents are at a higher risk than younger children of feeling the impact of stigmatization and self-blame.

Application of the Traumagenic Dynamics Model

The traumagenic dynamics model offers a complex assessment of trauma to use in the evaluation of the abuse experience, provides a way in which to examine how the abuse experience contributes to creating each of the traumagenic dynamics, and allows those working with survivors of CSA to anticipate the symptoms the child may display (Finkelhor & Browne, 1985). Any one of the dynamics can have a variety of behavioral outcomes that reflect the child who is abused, their developmental context, and the nature of the abuse. These behaviors and the emotional experiences associated with the abuse do not form one-to-one relationships with any of the dynamics, as some of the outcomes may overlap among the dynamics (Friedrich, et al., 1992), and clinicians working with CSA survivors should remember that progress in one dynamic does not always mean that there is also progress in another dynamic. However, by understanding which dynamics are most prevalent for the child, treatment planning and intervention strategies that target the specific dynamics the child displays and appropriately address the effects of the CSA can be formulated (Finkelhor & Browne, 1985).

Each of the traumagenic dynamics demonstrate how the interpretation of the trauma can alter a child's cognitive and/or emotional orientation to herself and to the world following the abuse, and influence the behaviors that occur as a result of the abuse (Finkelhor, 1987). Cognitively, traumagenic dynamics are conceptualized as cognitive appraisals that develop as a result of the trauma of CSA (Ramirez, 2009) and can impact the basic assumption one has about the world (Janoff-Bulman, 1989; Kendall-Tackett & Marshall, 1998). Children who have been sexually abused have their assumptions of the world negatively impacted so that instead of having a sense of safety, seeing the world as benevolent and meaningful, and the self as worthy, they may experience feelings of vulnerability and helplessness, an inability to trust the world or see it as benevolent, chronic perceptions of danger, and a diminished sense of self-worth and

self-acceptance. These cognitive distortions can also contribute to emotional distress and increase the risk of affective disorders such as depression, anger, anxiety, irritability, panic disorders, phobias, and obsessive-compulsive disorders (Briere & Elliot, 1994; Kendall-Tackett & Marshall, 1998).

Prior to the introduction of Finkelhor and Browne's (1985) traumagenic dynamics model, there was a tendency, when studying CSA, to examine only the abuse and ignore other contextual factors such as familial dynamics and ethnic differences that pre-dated, co-existed with, or occurred after the abuse (Ramirez, 1999). Finkelhor & Browne's (1985) model recognized the integral role these pre-abuse and post-abuse variables have in impacting the psychological outcome of the CSA survivor. Traumagenic dynamics do not apply only to the abusive event. The dynamics are conceptualized to be ongoing processes that are present prior to and following the abuse (Finkelhor & Browne, 1985). Before the abuse, the traumagenic dynamics are understood in relation to the child's family life and personality characteristics prior to the abuse. For example, the betrayal dynamic may be experienced to a lesser degree for a child who had a strong sense of trust established with her family prior to the abuse. Subsequent to the abuse, the traumagenic dynamics are understood in relation to the family's reaction to the disclosure and the social and institutional response to the disclosure. For example, a child may be relatively unstigmatized by the actual abuse but then may experience stigmatization if, upon disclosure, she is blamed by family members for the abuse (Finkelhor & Browne, 1985).

This model has been applied in many studies as a way in which to understand CSA and how cognitive perceptions of CSA survivors are connected to their emotions and behaviors (e.g., Cantón-Cortés, et al., 2013; Hazzard, et al., 1995; Coffey, et al., 1996; Edwards, 1997; Hazaard, 1993; Hazaard 1995; LeClair, 1993; Merryfield, 2001; Ramirez, 1999, Senn, et al.

2012). However, the majority of these studies have focused on the reactions to abuse displayed by adult survivors of CSA; few studies using the traumagenic dynamics model have examined the reactions shown by child or adolescent survivors. Since the effects of CSA can be seen in adulthood, it is critical that we begin to understand the effects that are experienced earlier. By doing so, interventions aimed at the specific reactions exhibited by youth can be implemented so that these reactions can be addressed and remedied early, thereby supporting the development of positive behaviors and relationships and avoiding these negative reactions and consequences later in life. Additionally, as Cantón-Cortés, et al., 2013) reported, many of the studies examining the traumagenic dynamics model have focused on an isolated dynamic, as opposed to examining the effects of several dynamics simultaneously. This has resulted in the examination of some dynamics at the expense of others. In order to understand the effect of traumagenic dynamics of CSA survivors, this study aimed to examine each of the traumagenic dynamic symptoms individually and as a whole. Finally, the majority of the studies examining the traumagenic dynamics model have explored the direct relationship between the dynamics and a measured outcome. Only recently has the utility of the model begun to be increased by examining factors such as family environment and ethnicity that mediate the behavioral outcomes (Ramirez, 2009). This study aimed to further the exploration of the efficacy of the traumagenic dynamics model by investigating the influence of trauma severity, exposure to domestic violence, perception of familial support, and sense of ethnic identity on the presence of the traumagenic dynamics of the adolescent girls, as well as how they affect the adolescent girls' attitudes towards romantic relationships.

Attitudes toward Romantic Relationships

A normative task of adolescence is the initiation and development of intimate and romantic relationships. These relationships are shaped by dating partners, peers, caregivers, and the broader social context (Connolly, Furman, & Konarski, 2000; Wolfe, et al., 2004). While romantic relationships can be enjoyable and pleasurable, they also carry the risk for abuse and violence that can become a pattern that repeats and escalates into adulthood (O'Leary, et al., 1994; Wolfe, et al., 2004). Relationship violence is comprised of a range of behaviors (e.g., insults, threats, intimidation, physical and sexual assault) that function to control, dominate, or harm the dating partner physically, sexually, or psychologically (Lewis & Fremouw, 2001; Wolfe, et al., 2004). Adolescents with histories of maltreatment are especially at risk for difficulties in romantic relationships due to the developmental processes affected by maltreatment that can interfere with or alter their ability to form healthy relationships (Wolfe, et al., 2004). Abused children are more likely than non-abused children to display fear, mistrust, and hostility in relationships, as well as experience limited personal resources such as poor problem solving, lower self-efficacy, and distorted beliefs about relationships (Wolfe, et al., 2004). In addition, maltreatment experiences can lead to difficulties in inferring emotional reactions in others, which can result in problematic interpersonal reactions with romantic partners (Rogosch, Cicchetti, & Aber, 1995).

Theoretical explanations for the occurrence of relationship violence include the social learning theory, attachment theory, and developmental trauma models. Each of these theories contributes a unique understanding of the romantic relationships of adolescents, how the experience of CSA can affect an adolescent's attitudes and experience in romantic relationships, and targets for intervention to encourage the development of healthy relationships.

Social Learning Theory

According to the social learning theory, behaviors are learned through observation and imitation of others, and are maintained through differential reinforcement of the imitated behaviors (Bandura, 1973). Using this model, it is theorized that abusive and aggressive conflict-resolution techniques are learned and reinforced, frequently at the expense of more adaptive methods of conflict resolution (Wolfe, et al., 2004). Based on this conceptualization, experiencing abuse as a child places the child at future risk for relationship violence because of the messages the child learns about the function of violence. These messages are that violence is used to express oneself, solve problems, and control others, and that violence is rewarded with the decrease of tension and conflict in the relationship (Wekerle & Wolfe, 1999). Further, social-cognitive factors such as self-efficacy and attitudes that emphasize the belief that aggression is normative, justifiable, expected, and likely to increase the likelihood of desired outcomes are likely to increase the probability of aggression occurring (Wolfe, et al., 2004).

Attachment Theory

Attachment theory posits that children form mental representations of relationships based on their relationships with their caregivers (Bowlby, 1982). The relationship with the caregiver serves as template or prototype for building future relationships, thereby creating a mental representation or internal working model that operates outside of one's awareness and yet remains fairly consistent throughout life. This internal working model provides a guideline for how one perceives the representation of the self, significant others, and the relationships between the two (Bowlby, 1982).

Attachment theory describes three main styles of attachment (Ainsworth, 1978). These are: (a) Secure, in which a young child may become upset by a brief separation with a caregiver

but willingly approaches the caregiver after the separation and is easily comforted by the her;

(b) Avoidant, in which a young child is not upset by a brief separation with a caregiver and resists contact with their caregiver after the separation; (c) Anxious-Ambivalent, in which a young child may become upset by a brief separation with a caregiver, push the caregiver away, and then become difficult to comfort after the separation. Secure attachments are derived from consistent and responsive child rearing, while insecure and anxious-ambivalent relationships are derived from inconsistent, aversive, intrusive, or unresponsive caregiving (Wekerle & Wolfe, 1999).

Hazaan and Shaver (1987) found that romantic relationships can also be conceptualized as an attachment process and determined that internal working models of relationships and oneself are related to attachment style. Healthy relationships result from secure attachments, and unhealthy relationships result from insecure attachments. These findings show that individuals with different attachment orientations hold differing beliefs about the course of romantic relationships, the availability and trustworthiness of partners, and their own worthiness in being loved. These beliefs may be a part of a cycle in which one's early experiences affect their beliefs about themselves and others, and these beliefs then affect their behavior and the outcomes of the relationship. Since continuity is seen between early attachment patterns and adult relationships, the continuity between childhood and adolescence should then be even greater since there is less of an opportunity to revise the attachment model due to there being less time passed and fewer relationships experienced (Hazaan & Shaver, 1987).

Research has determined that an insecure attachment style describes adolescents who are at high-risk both for victimization and offending in intimate relationships (Wekerle & Wolfe, 1998). As a consequence of child maltreatment, attachment is constructed along the dimensions of dominance-subordination and victimizer-victim (Crittenden & Ainsworth, 1989). The

experience of abuse teaches a child that there are extreme power differentials in significant relationships, resulting in some children associating passivity and a sense of personal deprivation and others associating aggression and personal entitlement with these relationships. Since attachment models are consistent over time, adolescent then may select dating partners and situations that are consistent with their understanding of what relationships are, their role in relationships, and their expectations from their partner (Wekerle & Wolfe, 1999).

Developmental Trauma Model

The model of developmental traumatology (DeBellis & Putnam, 1994) suggests that the symptoms related to trauma mediate between maltreatment history and the subsequent outcomes caused by stress-induced changes in developing neurobiology. In response to abuse and to chronic stressors in the family, the child's biological stress system response is chronically mobilized, and this can lead to structural and functional changes in the brain (DeBellis, 2001). Post-traumatic symptoms frequently endorsed by adolescents (e.g., intrusive memories, numbness, distressing reminders, dissociative responses, efforts to forget about the abuse, hypervigilance, and reliving the trauma) can compromise the cognitive and behavioral responses of the adolescent (Wekerle & Wolfe, 1999). In relation to romantic relationships, these symptoms may interfere with acknowledging when playfulness crosses the line into abusive behavior because of the positive affect experienced in the earlier stages. It may also create a potential for heightened tolerance of abuse experiences among survivors of abuse (Wekerle & Wolfe, 1999). Therefore, the entrance into dating brings challenges for adolescent survivors of abuse because the strong feelings, physical proximity, and sexual engagement that are involved in romantic relationships may share similar cues to the childhood event(s) of abuse, thereby playing a role in the reappearance of trauma symptoms (Wekerle & Wolfe, 2003).

Adolescent Romantic Relationships

Research investigating the relationship between abuse and functioning in romantic relationships has only begun to examine relationships in adolescents over the past decade (Wolfe, et al., 2004). Before this, most explorations of this connection occurred by researching adult relationships (e.g., DiLillo, 2001; Mullen, et al., 1996). It is important that research be targeted specifically toward adolescents as their experience of dating can differ drastically from that of adults. Teen dating is characterized by rapid turnover of relationship, peer pressures, and family pressures (O'Leary & Slep, 2003). It is also associated with more gender-equal approaches to conflict (O'Leary & Slep, 2003), suggesting that relationship behaviors during these years are not yet in an adult-like pattern, allowing for an opportunity to modify emerging patterns and encourage the development of healthy relationship behaviors (Wekerle & Wolfe, 1998).

The research that has been done examining the relationship between abuse and adolescent romantic relationships thus far has generally grouped various forms of abuse, so that results of neglect and physical, sexual, and emotional abuse have all been examined together (e.g., Wolfe, et al., 2004). Hence, there has been little distinction as to the specific effects of sexual abuse versus other forms of abuse. However, some research has begun to be conducted that looks at the specific relationship between CSA and dating. This includes Cyr, McDuff, and Wright's (2006) finding that out of 126 female CSA survivors aged 13 to 17, 45% reported experiencing some kind of physical violence in their romantic relationships, and 90% reported experiencing psychological violence, as well as the Centers for Disease Control and Prevention's (2010) report that 10% of adolescents overall report being physically harmed by a romantic partner and 25% of adolescents report experiencing any type of dating violence.

A connecting thread in the examination of the relationship between CSA and dating is that CSA can be related to difficulties and violence in the romantic relationships of adolescents, and that these difficulties are associated with dire psychological and behavioral results such as performing poorly academically, binge drinking, attempting suicide, and physically fighting, as well as carrying the pattern of violence into adult relationships (Centers For Disease Control And Prevention, 2011). Due to these outcomes, it is imperative to understand the factors that lead to adolescent survivors of sexual abuse experiencing unhealthy attitudes towards romantic relationships at a much higher frequency than other adolescents. Through understanding these factors, intervention and prevention efforts targeting this population can be created and implemented to lower the prevalence of this violence.

Intervention in abusive romantic relationships is not a sufficient goal; prevention is the ultimate aspiration. To understand how to work with adolescent female CSA survivors to prevent their participation in unhealthy or abusive relationships, their attitudes towards romantic relationships can be assessed. Attitudes supporting relationship violence are related to sexual, psychological, and physical abuse of dating partners (Bookwala, et al., 1992; Check & Malamuth, 1985; McDonell, et al., 2010; Price, et al., 1999). For instance, Bookwala, et al. (1992) surveyed 305 undergraduate students to determine a pattern of predictors associated with engaging in dating violence. Using the predictors of attitudes toward violence, sex-role attitudes, romantic jealousy, general levels of interpersonal aggression, verbal aggression, and verbal and physical aggression received from one's partner, the researchers conducted multiple regression analyses and found attitudes toward violence was a significant predictor of expressed violence. Since attitudes toward dating can be present before an adolescent is in a romantic relationship, and since relationship attitudes and relationship violence have repeatedly found to be related,

relationship attitudes are both a good way to understand how adolescents feel about romantic relationships, and are a point of intervention in working with adolescents before they may become involved in relationship violence. For this reason, attitudes towards romantic relationships were assessed in the present study in order to understand how the experience of CSA can affect attitudes toward relationships and, subsequently, the behaviors in romantic relationships of adolescent CSA survivors.

Risk and Protective Factors

CSA interventions have traditionally looked to reduce the abusive behaviors, the incidents of abuse, and the risk factors leading to abuse (Ross & Vandivere, 2009). Risk factors are the characteristics of a person or environment that are associated with an increased probability of maladaptive developmental outcomes. More recently, however, there has been a greater focus on examining increasing protective factors that may lead to displays of resilience for children and families who have experienced childhood abuse. This focus has created a strengths-based framework in conceptualizing the effects of abuse (Counts, Buffington, Chang-Rios, Rasmussen & Preacher, 2010). The benefit to using this framework is that it focuses on factors that respond to prevention strategies. While many risk factors may not be amenable to interventions, protective factors, such as the behaviors and attitudes of CSA survivors and their families, can be changed through interventions (Ross & Vandivere, 2009).

Protective factors are the personal resources and social context factors that are nested within sources of family and community support (Aguilar-Cafaie, et al., 2011), and they function by increasing the possibilities of pro-social behaviors and norms (Beauvis & Oetting, 1999), thereby promoting resilience. The presence of protective factors is associated with lower levels

of negative outcomes, and the absence of protective factors is predictive of substantially greater psychological, emotional and/ or behavioral problems (Moran & Eckenrode, 1992).

Protective factors have been identified as enhancing resilience. Since it first began to be examined approximately 50 years ago, the definition of resilience has shifted from being based on a deficits model to one that uses a strengths perspective (Prince-Embury, 2008; Brodeur, 2009). One of the earliest definitions was by Rutter (1985), who defined resilience as the absence of psychopathology when discovering that not all children of parents with mental disorders develop psychopathology as adults. Later, Werner and Smith (1982, 1992) researched the risk factors for trauma (such as living in poverty and experiencing family conflict) that were exhibited in Hawaiian children. In this exploration, they defined resilience as competence that is sustained when one is under stress. Around this same time, Garmezy (1991) defined resiliency as “the capacity for recovery and maintained adaptive behavior that may follow initial retreat or incapacity upon initiating a stressful event” (p.459), and Rutter (1987) revised his definition of resilience to say it referred to “the positive role of individual differences in people’s response to stress and adversity” (p. 316). More recently, Prince-Embury (2008) has defined it as “the ability to weather adversity or to bounce back from negative experience” (p.11). It has been stated that the processes that underlie resilience may build over time and across a number of domains such as psychological well-being, physical health, and romantic relationships (Wright, Fopma-Loy, & Fischer, 2005).

Protective factors are distinct from resilience, in that protective factors are consistent and always in operation, while the process of resiliency operates only in the face of adversity (Beauvis & Oetting, 1999). Although the concept of resiliency has been examined in CSA survivors (e.g., Himelein & McElrath, 1996; Singh, 2009; Wright, et al., 2005), the protective

factors that have been examined have been mainly in the intrapersonal (e.g., psychological health), interpersonal (e.g., familial support), and intrafamilial (e.g., family characteristics) domains (Wright, et al., 2005), and have mainly been examined in adults. The present study will examine protective factors in the broader cultural domain in adolescents. In this study, the protective factors being investigated are perception of familial support and sense of ethnic identity and the risk factors are trauma severity and exposure to domestic violence.

Social Support

Social support (e.g., friends, family) has been identified as a contributor to well-being and as having a positive relationship with mental health (Cohen & Wills, 1985). Social support has been defined as the “information leading the individual to believe that he or she is cared for, loved, esteemed, and valued, and is a member of a network of communication” (Cobb, 1976; p. 300). The presence of supportive individuals in one’s life is associated with better adjustment in both the short-term and long-term (Cohen & Wills, 1985; Teja & Stolberg, 1993; Wills, 1985; Tremblay, et al., 1999). Cohen and Wills (1985) proposed two models to explain the positive effect of social support: the main effect model and the buffering effect model. The main effect model posits that social support may have an influence on one’s well-being that is independent of the situation. Meaning that irrespective of whether a person is under stress, social support has a beneficial effect and that this relationship may be due to a multitude of factors including: positive affect, predictability and stability in one’s life, recognition of self-worth, and avoidance of negative experiences (Cohen & Wills, 1985). Alternatively, the buffering effect model posits that social support is related to well-being primarily for individuals under stress. This model theorizes that social support protects one from the potentially pathogenic influence of stressful events (Cohen & Wills, 1985) and may do this by intervening between the stressful event and a

reaction to it by attenuating or preventing the reaction. This is thought to occur because the perception that others can and will provide the necessary resources may bolster one's perceived ability to cope with the demands required by the situation. The buffering effect model also states that social support may intervene between the experience of stress and the onset of the reaction to the stress by reducing the perceived importance of the problem so that it alleviates the resultant impact and reduces or eliminates the stress reaction (Cohen & Wills, 1985).

There are four defining attributes of social support that have been discussed in the literature: emotional support, informational support, appraisal support, and instrumental support (Cohen & Wills, 1985; Langford, Bowsher, Maloney, & Lillis, 1997). Emotional support has also been referred to as esteem, self-esteem, expressive support, and close support (Cobb, 1976; House, 1981; Langford, et al., 1997; Wills, 1985). It refers to the provision of caring, empathy, love, trust, and the enhancement of self-esteem through communication to individuals that they are accepted, cared for and loved, esteemed and valued, and belong to a network of mutual obligation (Cobb, 1976; Cohen & Wills, 1985; Langford, et al., 1997). Informational support has also been referred to as advice and cognitive guidance (Cohen & Wills, 1985). It refers to the help and information one is provided in defining, understanding, and coping with problematic events (Cohen & Wills, 1985; House, 1981; Krause, 1986; Langford, et al., 1997). Appraisal support has also been referred to as affirmational support (Kahn & Antonucci, 1980) and refers to the communication of information to an individual that is relevant to his or her self-evaluation (Langford, et al., 1997). Instrumental support has also been referred to as aid, material support, and tangible support (Cohen & Wills, 1985; Tilden & Weinert, 1987; Langford, et al., 1997). It refers to the concrete assistance that can be provided to a person to help with the resolution of a problem (Cohen & Wills, 1985; Langford, et al., 1997).

Each of the four attributes of social support is considered a protective factor to the person receiving the support (Langford, e. al., 1997). It has been hypothesized that the attribute of social support can mitigate the effects of stressful events because the appraisal of stressful events often results in feelings of helplessness and a threat to self-esteem, while emotional support can bolster self-esteem, informational and attributional support can help one to appraise the stressor as benign and even suggest coping responses that are appropriate for oneself. Additionally, instrumental support is effective when the resources that are provided are closely linked to the need that is elicited by the event (e.g., stressors caused by economic difficulties may be reduced by the instrumental support of financial aid; Cohen & Wills, 1985).

Family Support as a Protective Factor

Social support has been examined in relation to a variety of stressors such as child maltreatment, interpersonal stress, financial difficulties, occupational event, physical health problems, intimate partner violence, and legal issues (Richards & Branch, 2012; Cobb, 1976; Cohen & Wills, 1985; House, 1981; Langford, et al., 1997; Merrill, Thomsen, Sinclair, Gold, and Milner, 2001; Moak & Agrawal, 2009) and in relation to a variety of outcomes such as life satisfaction, overall happiness, behavioral problems, PTSD, depression, and physical symptoms (Cohen & Wills, 1985; Langford et al., 1997; Moak & Agrawal, 2009).

The source of the support may differentially affect a child's level of adjustment following the disclosure of abuse (Feiring, et al., 1998; Tremblay, et al., 1999). Although adolescents involved in violent relationships have reported lower levels of social support from both family and friends (Richard & Branch, 2012), children and adolescents who receive their primary support from their parents tend to be better adjusted than those who received their primary support from other relatives or friends. Additionally, the relationship between social support and

the health and psychological well-being of ethnic minorities has been well documented and has concluded that for the most part, ethnic minority individuals' social support comes from their families (e.g., Balgopal, 1988; Birman & Trickett, 2001; Birman, Trickett, & Vinokurov, 2002; Gaylord-Harden, Ragsdale, Mandara, Richards, and Petersen, 2007; Kenny & Stryker, 1996; Liang & Bogat, 1994). For these reasons, the social support category of one's perspective of familial support was examined in the present study as a protective factor in relation to the outcome measures of traumagenic dynamic symptoms and attitudes towards interpersonal relationships in adolescent girls who have been sexually abused.

In examining the relationship between family and abuse, abused children who receive maternal support have been shown to exhibit less psychological symptomatology (Leifer, Kilbane, and Grossman, 2001). Additionally, caregiver support has been stated to be a "critical mediating factor in determining how children adapt to victimization" (Cook et al., 2005, p. 395), and familial support has been said to enhance a child's capacity to resolve these symptoms (Cohen, Mannarino, & Deblinger, 2000). The support that is received from parental figures has been found to mitigate the development of psychological symptoms, enhance a child's capacity to be associated with emotional and behavioral adjustment following their victimization, and leads to fewer symptoms of distress (Elliott & Carnes, 2001). Furthermore, abused children with supportive caretakers are more likely to disclose and less likely to recant their allegations than children without supportive caretakers (Elliott & Briere, 1994). Finally, it has been stated that because parental support is able to be modified and can be a target of treatment, it can serve as a protective factor that can exert a great impact on a child's adjustment over time (Elliott & Carnes, 2001).

Spaccarelli (1994) has proposed that levels of support resources, along with the stress resulting from the characteristics of the abuse and the results of the disclosure, predict later symptomatology. In support of this idea, researchers have found significant relationships between a positive perception of social support that one receives and fewer adjustment difficulties in survivors of CSA. For instance, Tremblay, et al. (1999) examined social support as a mediator to the children's adaptation following CSA using 50 children, aged 7-12, who had been sexually abused and found that social support exerted a direct effect on the children's adjustment following the abuse. Further, an exploration of the relationship between social support and multiple forms of child abuse and neglect (physical, sexual, and emotional abuse, neglect, witnessing family violence) by Vranceanu, et al. (2007) found that social support partially mediated the impact of abuse on the presence of PTSD symptomatology, and though it was not directly predictive of depression, it may impact depression through an indirect path. Using Spaccarelli's (1994) theory, Merrill, et al. (2001) examined how the functioning of women who had experienced CSA was effected directly by parental support and by parental support as mediated by the coping strategies one employs. They found that parental support was not uniquely helpful to survivors of CSA, but that it had equally beneficial benefits for non-CSA victims. They also found that a lack of parental support was significantly predictive of the presence of psychological symptoms in adulthood and associated with greater impairment and increased symptoms in women who had experienced CSA. Finally, they found that although parental support did not protect against the use of maladaptive coping strategies, it was a significant predictor of the use of constructive coping strategies, which was found to have a slightly negative relationship to psychological symptomatology. Also examining familial support, Esparza (1993) measured the quality of parent-child relationship between 20 mother-

daughter pairs in which the child was sexually abused by a nonfamily member and compared this to 50 control mother-daughter pairs. The results indicated that those girls who perceived their mother to be supportive after she disclosed CSA showed significantly fewer behavioral difficulties. Finally, Spaccarelli and Kim (1995) found that perceived support was the best predictor of a CSA survivor's adjustment among all the variables that were considered (cognitive appraisal of the abusive relationship, abuse related stress, coping behaviors), and that the children who felt they were supported by the non-offending parent had a higher level of functioning in social, interpersonal, and academic domains.

Recently, the relationship between social support and ethnic identity has been examined. Gaylord-Harden et al. (2007) determined that perceived support is predictive of ethnic identity and found that supportive relationships with family and friends may become part of an adolescent's internal working model of relationships, and that these working models may then be generalized to other members of their ethnic group, thereby contributing to positive feelings towards their ethnic group. The role of ethnic identity as a protective factor is discussed below.

Ethnic Identity

Ethnic identity refers to "one's sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings and behavior that is due to group membership" (Rotherham & Phinney, 1987, p.13). Ethnic identity includes a commitment and sense of belonging, positive evaluation of, interest in, knowledge about, and involvement in one's group (Phinney, 1993). The construct of ethnic identity differs from that of racial identity because racial identity focuses on the responses to racism and the experiences of internalized racism (Helms, 1990), while ethnic identity is concerned with one's sense of belonging to an ethnic group. As an aspect of

identity, the experience of ethnic identity is of particular importance during adolescence as identity formation is one of the central tasks of adolescence (Phinney, 1992, Erickson, 1968).

Ethnic identity is associated with group identity, which is the positive sense of belonging to one's group, which in turn is associated with positive self-esteem (Phinney, Cantu, & Kurtz, 1997). This linkage is based on social identity theory (Tajfel & Turner, 1986), which states that social identity consists of the aspects of one's self-image that derive from the social categories to which one perceives oneself as belonging. Social identity theory explains that group members differentiate their own group from other groups and evaluate their own group more favorably as a means of enhancing their own self-image. Phinney et al. (1997) further explain that a positive sense of belonging to one's group should enhance self-esteem, but negative attitudes and feelings about one's group may reduce self-esteem.

According to Phinney & Ong (2007), the literature has proposed a number of dimensions of ethnic identity. The dimension of self-categorization is the self-identification of oneself as a member of a particular social grouping. Depending on the situation, individuals may use different self-labels or categories. The label that is used is influenced by the context one is in, and by how one is viewed and perceived by others (Portes & Rumbaut, 2001). The dimension of commitment and attachment refers to one's sense of belonging, and according to Phinney & Ong (2007), it may be the most important component of ethnic identity. Further, when the term "ethnic identity" is used in everyday language, the idea of commitment is what is most often meant (Phinney & Ong, 2007); however, the strength of the commitment to an ethnic identity does not necessarily relate to the content (specific attitudes and worldviews) of the identity one holds (Cokely, 2005). The dimension of exploration is the seeking of information and experiences that are relevant to one's ethnicity, and is essential to the process of ethnic identity

formation. Although this dimension is an ongoing process that can continue throughout life, it is most common in adolescence. Without the process of exploration, one's commitment may be less secure and subject to change more with novel experiences (Phinney & Ong, 2007). The dimension of evaluation and in-group attitudes refers to the attitudes one holds about his or her group and being a member of the group (Phinney & Ong, 2007). Positive attitudes towards one's group are a part of an achieved ethnic identity. An achieved ethnic identity means that attitudes about one's group have been examined and evaluated and are not simply the internalization of what others think (Phinney & Ong, 2007). This is important because members of minority groups are often subject to discrimination that can lead to negative in-group attitudes (Tajfel, 1978), and the formation of an achieved ethnic identity leads to the rejection of negative views towards one's group (Phinney, 1989). The dimension of importance and salience refers to the value one places on their ethnic identity. Members of ethnic minority groups have been reported to attribute greater importance to their ethnicity than members of majority groups (Phinney & Ong, 2007). Additionally, those with a stronger ethnic identity have been reported to have higher ethnic identity salience, and salience is associated with positive well-being for those with high ethnic identity but not for those low in ethnic identity (Yip & Fuligni, 2002).

A developmental perspective that has its roots in the ego identity model of Erickson (1968) has been widely used in understanding ethnic identity and how to measure it (Phinney & Ong, 2007). This model refers to identity as that which provides the stable sense of self one uses to guide the choices made in key areas of one's life (Phinney & Ong, 2007). It develops over time, beginning in childhood, and undergoes a major change during adolescence and young adulthood (Phinney, 1989, 1993). The drive toward discovering one's identity is often considered the quintessential task of the adolescent years (Erickson, 1968; Holleran and Waller,

2003). Ethnic identity is one aspect of identity. As a person develops, she moves from lacking a clear ethnic identity (diffusion) to exploring the identity (moratorium) or to committing to the identity without exploring it (foreclosure), and finally to firmly committing to one's ethnic group due to exploration that leads to a clear understanding of one's ethnicity (achievement). This end state reflects the acquisition of a stable and secure sense of oneself as a member of his or her ethnic group (Phinney & Ong, 2007). Not all individuals achieve a stable ethnic identity. However, research has shown that obtaining an achieved identity, in which a stable sense of self is established, is associated with psychological well-being (Phinney & Ong, 2007). Like personal identity, ethnic identity also refers to a sense of self, though it differs in that it also includes a shared sense of identity with others who are members of the same ethnic group (Phinney & Ong, 2007). Additionally, ethnic identity contributes to individuals' well-being, and people also gain positive self-attitudes from belonging to groups that hold meaning for them (Phinney 1989; Tajfel & Turner, 1986).

Ethnic Identity as a Protective Factor

It has been suggested that adhering to traditional values and beliefs is a source of strength and can promote resilience in the face of obstacles and provide strategies for coping and adaptation (Saleeby, 1997). A number of researchers have stated that ethnic identity is a protective factor for racial and ethnic minorities that facilitates positive and healthy development and adjustment (LaFromboise, Coleman, & Gerton, 1993; Lee, 2005; Operario & Fiske, 2001; Phinney, 1990, 1992; Phinney, Cantu, & Kurtz, 1997), psychological well-being, psychosocial competence, and successful adaptation into society (Spencer & Markstrom-Adams, 1990; Phinney, 1991), positive social interactions with others and resilience (Hackett, et al., 1992; Holleran & Waller, 2003; Phinney & Kohatsu, 1997), academic outcomes (e.g., Orozco, 2007; Weaver, 2009) self-esteem (e.g., Adams, Shea & Fitch, 1979; Phinney & Alipura, 1990;

Phinney, et al., 1997) and psychological well-being in the face of racial and/or ethnic discrimination (e.g., Lee, 2005; Yoo & Lee, 2008; McCubbin, 2004; Borsato, 2008), and that it is associated with better adjustment in ethnic minority youth (Bruce & Waelde, 2008).

As a protective factor, a high degree of ethnic identity has been found to counteract discrimination and other risk factors faced by youth. For instance, in a large-scale epidemiological study, Mossakowski (2003) investigated whether ethnic identity is linked to mental health and if it reduced the stress of discrimination in Filipino Americans. Results concluded that greater strength of ethnic identity was directly associated with fewer depressive symptoms, buffered the stress of racial/ethnic discrimination, and served as a coping resource for minority individuals. Wong, Eccles, and Sameroff (2003) found that the connection to one's ethnic group acts as a protective factor by compensating for and buffering against the impact of perceived ethnic discrimination and the potential threats (academic motivation, school performance, self-esteem, group-esteem, psychological distress, selection of friends, problem behaviors) posed by experiences of ethnic discrimination in African-American adolescents.

Other studies have had more mixed findings regarding the protective value of ethnic identity. Dixon, Rayle, and Myers (2004) examined the role of ethnic identity on the wellness of high school students (using the areas of spirituality, self-direction, schoolwork, leisure, love, and friendship). Although they found that ethnic identity was not related to wellness in non-minority students, it was related to five of the six areas of wellness (spirituality, schoolwork, leisure, love, and friendship) in ethnic minority students, illustrating the importance of ethnic identity in the psychological well-being of minority students. However, in another study testing if ethnic identity moderated the impact of frequent racial discrimination on one's affect, Yoo & Lee

(2008) found that ethnic identity may actually serve to exacerbate the association between racial discrimination and well-being.

Ethnic identity has also been examined in relation to resilience. McCubbin (2004) examined the relationship between psychological distress and well-being in native Hawaiian adolescents and found that ethnic identity predicted lower symptoms of depression and anxiety and positively predicted higher levels of self-acceptance and growth in this population. However, this study did not find ethnic identity to have a moderating effect between stressors and psychological outcomes, so ethnic identity was found to serve only as a protective factor and not a factor that operates as a part of the process of resilience. However, Weaver (2009) did find evidence that there is a positive relationship between ethnic identity and resilience via a positive relationship that was found between ethnic identity and the individual protective factors of optimism, self-efficacy, interpersonal sensitivity, and emotional control that defined resilience in this study. Lee (2005) investigated the resilience of Korean American college students in the context of perceived ethnic discrimination and found that one aspect of ethnic identity, ethnic identity pride, operated as a positive factor that moderated the effects of discrimination on depressive symptoms and social connectedness. Holleran & Waller (2003) examined the relationship between ethnic identity and resilience in Chicano youth aged 13-18, explaining that these youth encounter risk factors that include poor schools, limited employment opportunities, and neighborhoods, with considerable gang activity, violence, and drug problems. They found that a strong, positive ethnic identity may serve as a protective factor that contributes to resilience among these youth. They concluded that Chicano adolescents draw upon traditional cultural values and beliefs as a way to make meaning and cope with their worlds and that the pride these adolescents hold in their cultural traditions and practices plays an integral role in

counteracting negative stereotypes the dominant culture may attribute to them. Finally, Borsato (2008) investigated the relationship between ethnic identity and resilience in 7th and 8th grade Asian-American, Latino, and Caucasian students at a public junior high school in northern California and found that ethnic identity emerged as a protective factor in relation to depressive symptoms and academic motivation but did play a protective role in relation to problematic behavior or GPA. The researcher explained that the disparity of the findings of this study, when compared to other studies that have found evidence for the protective role ethnic identity plays, may be explained by the fact that the students in this sample had not yet reached adolescence, which is the time when identity exploration and formation are most salient.

While there have been some mixed findings, the majority of studies have found evidence of ethnic identity playing a protective role in the psychological well-being of adolescents from minority backgrounds. The majority of the studies that have examined this have focused on a general population of adolescents. The protective role that ethnic identity may play in the lives of adolescents who have experienced trauma in general, or CSA specifically has only recently begun to be examined.

Ethnic Identity as a Protective Factor in Trauma

Although there is a paucity of research examining whether ethnic identity serves as a protective factor in the face of experiencing trauma, the importance of examining ethnicity in relationship to both trauma in general, and CSA in particular, is now beginning to be explored.

In one of the few studies examining the relationship between ethnic identity and trauma, Kaiser (2000) examined whether ethnic identity was associated with PTSD symptomatology in a sample of adolescents who had experienced or witnessed traumatic events (assault, child abuse, rape, child neglect, molestation, fire or flood, accident, electric shock, or threat). Although she

found no evidence for a significant or positive association of ethnic identity with PTSD symptoms, she stressed that the role that ethnic identity plays in the development of PTSD is still theoretically nebulous, and that further study of this relationship is warranted. Another study that examined similar constructs but found evidence of a relationship between ethnic identity and the experience of trauma was conducted by Bruce and Waelde (2008). They investigated an ethnically and diverse sample of junior high and high school students and found that greater levels of ethnic identity were related to less delinquency in the face of increasing trauma symptom levels, and that this effect was particularly salient in ethnic minority youth, suggesting that ethnic identity may be an important resource to protect against the effects of trauma in this group.

Although there is a dearth of research examining whether ethnic identity has a protective role for individuals who have experienced trauma, there have been researchers who have discussed the necessity for examining the effects of ethnicity on individuals who have had traumatic experiences. For instance, Behl, Crouch, May, Valente, and Conyngham (2001) completed a content analysis of 1,133 articles published on the subject of child abuse between 1977 and 1998, finding that only 6.7% of the articles focused on ethnicity and that a majority of the articles did not include ethnicity in their analyses or design. They explained that in order to promote culturally competent responses to child maltreatment, research is needed that examines whether risk factors, protective factors, etiological processes, or reactions to child maltreatment differ by ethnic group.

Fontes and Plummer (2009) explored the cultural norms that affect the likelihood of CSA being discovered by an adult or being disclosed by the child, and the likelihood of the CSA being reported to authorities. They explain that among others, the issues include: shame; taboos; modesty; sexual scripts (e.g., the man should always want sex and the woman should try to avoid

it); emphasis on virginity; the devalued status of females; obligatory violence toward the abuser by the abused's relatives; honor, respect, and patriarchy; and religious values (e.g., accepting the abuse as a struggle to bear, seeing a father figure as having the rights to do as he pleases, just as the "infallible Father in heaven" does; Fontes & Plummer, 2010, p. 502), seeing the abuse as retribution for a past deed committed in a previous life, or the claim of a religious justification for abuse based on practices by prophets of one's religion (e.g., Mohammad's six-year-old bride in Islam and Joseph Smith and Brigham Young's child brides in the Church of Jesus Christ of Latter Day Saints) present differently in various cultures and thereby affect the response to CSA differently. For instance, when examining sexual scripts, the authors describe a psychoeducational group in which low-income Puerto Rican parents explain that the difference between raising girls and boys is that girls need to be educated at a young age to "keep their legs closed," hide their bodies, and avoid arousing men. They further explain that if a girl is abused in a culture that follows these sexual scripts, abuse may be seen as the girl's fault for tempting a man, and the male abuser is viewed as "having done what boys or men will do" (Fontes & Plummer, 2009, p. 498). Cohen, Deblinger, Mannarino, & de Arellano (2001) support the claims that ethnicity may affect the reaction children have following CSA. They explain that differences among ethnic groups in how sexuality, nudity, virginity, and intrafamilial boundaries are viewed may explain some of these differences. Additionally, shame about discussing negative feelings, parental emotional distress related to the CSA, and/or fear of involvement with child protection and /or police may also influence the reaction to CSA.

Cultural norms do not only preclude the disclosure of CSA, they may also facilitate CSA disclosure. For example, the mother-child relationship often plays a central role in cultural practices (Fontes & Plummer, 2009), and this relationship can predict improved outcomes for

children who have been abused (Deblinger, Stauffer, & Landsberg, 1994). Additional cultural factors that can protect children who have been sexually abused include: the intolerance of adult sexual practices with children, highly valuing women and children; extended family supervision of children; men's direct involvement in raising children; close mother-child relationships; strong social sanctions against abuse; and views of children as being non-sexual (Fontes & Plummer, 2009).

Cohen, Deblinger, Mannarino, & de Arellano (2001) state that cultural factors may also have an impact on whether treatment is necessary after CSA disclosure and, if so, the type of treatment that is appropriate. For example, they explain that African American and Latino clients may respond well to brief, goal-directed, problem-oriented treatment approaches because it is more action-oriented, problem-specific, and directive. They also explain that the social stigma regarding psychological treatment may be more severe among some cultural groups, and that this can lead to individuals denying or hiding symptoms until they have become very severe. In understanding that cultural groups may have varying responses to both CSA and CSA treatment, it seems imperative that the degree to which a CSA survivor identifies with her ethnic group be assessed. By collecting this information, the clinician can determine whether the survivor may or may not subscribe to traditional cultural values in regards to CSA and the related treatment, thereby informing the clinician as to the most appropriate treatment options.

Since cultural norms and beliefs may serve both as protective and risk factors for dealing with CSA, it is important to determine how ethnic identity affects a child's psychological adjustment after experiencing CSA. If ethnic identity serves as a protective factor, this is something that can be integrated into interventions with the abuse survivors. If it serves as a risk factor, then this is something that should be identified and considered when working with these

survivors. Therefore, regardless of the direction of the relationship between ethnic identity and psychological well-being after CSA, it is essential for practitioners working with children who have been sexually abused to gain an understanding of the ethnic identification a child holds, as well as what their belief systems are, in order to provide the most effective treatment.

Trauma Severity

The severity of the CSA a child experiences is related to greater psychological symptomatology such as more severe symptoms of PTSD, behavioral problems, sexualized behaviors, poor self-esteem (Kendall-Tackett, et al., 1993; Wolfe, Gentile, & Wolfe, 1989; Wolfe, Sas, & Wekerle, 1994), avoidant coping, sexual revictimization (Fortier et al., 2009), risky sexual behavior (including more lifetime sexual partners, more unprotected sex, and a history of sexually transmitted infections, sexual problems, negative sexual self-concept; Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012; Lemieux & Byers, 2008), and psychiatric disorders including depression, phobias, obsessive-compulsive disorder, panic disorder, PTSD, sexual disorders, suicidal ideation, and suicide attempts (Putnam, 2003; Saunders, Vileponteaux, Lipovsky, Kilpatrick, & Vernon, 1992).

Although there are a number of empirically validated measures assessing the impact of CSA such as The Children's Impact of Traumatic Events (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991), Sexual Abuse Fear Evaluation (Wolfe & Wolfe, 1986), and the Trauma Symptom Checklist (Briere, 1995), historically, the severity of abuse has been defined in an informal and almost ad hoc manner (Chaffin, 1997). The definitions of what constitutes severe versus less severe abuse have often been unique to a specific study and consisted of intuition-based groupings of abusive behaviors (Chaffin, et al., 1997; Kendall-Tackett, et al., 1993; Kallstrom-Fuqua et al., 2004; Wolfe Gentile & Wolfe, 1989). For example, in one of the earliest studies

examining the effects of abuse severity, Russell (1983) divided sexual abuse into three categories that were based on severity but had no empirical backing as to why certain acts were placed under certain severity categorizations. According to Russell, the category consisting of the most severe abuse included forced penile penetration and fellatio, the second category included digital penetration and simulated intercourse, and the category of least severity consisted of clothed fondling and forced kissing. Other studies have divided the categorization of the CSA into contact abuse (which includes any sexual touching, genital contact, and/or penetration) and noncontact abuse (which includes exposure to sexual suggestions and/or exhibitionism; e.g., Mullen, et al., 1996) or simply divided the categorization of CSA by the presence or absence of penetration (e.g., Briere & Elliott, 2003), since abuse containing some form of penetration has been found to produce more psychological symptomatology than abuse without penetrations (Kendall-Tackett, et al., 1993). Other indicators that have been used to determine sexual abuse severity include level of coercion, perpetrator identity, number of perpetrators, and number of assaults (Chaffin, et al., 1997; Feiring et al., 2002; Kallstrom-Fuqua, et al., 2004; Kendall-Tackett et al., 1993). Although the way abuse severity has been defined often occurs without empirical backing, these intuitive groups that have been used so frequently have shown a great consensus as to what constitutes more severe versus less severe behavior. For instance, intercourse is almost always classified as a more severe form of sexual behavior than fondling (Chaffin, et al., 1997). Additionally, when Chaffin (1997) sought to create an empirical measure of abuse severity, he interviewed 200 randomly selected child abuse mental health professionals and found a high degree of consensus among them in regards to the relative severity of different CSA behaviors (for example, intercourse was almost always classified as being of greater severity than fondling).

In attempting to determine a method to measure severity, there has been recognition that the construct is multidimensional and involves a number of facets. Some of the features that have been suggested to impact the severity of symptomatology are the nature of the abusive behaviors, the number and duration of the behaviors, the accompanying use of force or coercion, the relationship between the child and the abuser, the age at the time of abuse, the age at the time of disclosure and assessment, the number of abusers, medical findings, and how the case was confirmed (Briere & Elliott, 1994; Chaffin, et al., 1997; Kendall-Tackett, et al., 1993; Rosenthal, Feiring, & Taska, 2003; Zink, et al., 2009). A meta-analysis of 45 quantitative studies of sexually abused children by Kendall-Tackett, et al. (1993) found that CSA that included abuse by a perpetrator who had a close relationship with the child, a high frequency of sexual contact, a long duration, used force, included oral, anal, or vaginal penetration, lack of maternal support, and a negative outlook by the victim led to a greater number of symptoms for abused individuals. Additionally, age at time of assessment, age at onset of abuse, the number of perpetrators, and time elapsed between the end of abuse and assessment also showed some relation to increased symptomatology.

In trying to empirically measure severity of CSA, a few measurement methods have been explored. Chaffin (1997) created a measure for 7-12 years old assessing abuse severity using a semi-structured interview. The facets of abuse that are assessed in this measurement are the behaviors, duration, frequency, and total of incidents of CSA, as well as the reaction of the abuser upon disclosure, the use of force or coercion in the abuse, the use of coercion to gain secrecy, and the role of the abuser in the child's life. Zink, et al. (2009) and Feiring, Taska, and Lewis (2002) both have used checklists of for adults and adolescents, respectively, to examine various abuse characteristics. Zink et al. (2009) has scored the characteristics based on severity,

while Feiring et al. (2002) has given a score only if the most severe item of a given category (e.g., penetration for type of abuse, perpetrator living with child for relationship between perpetrator and child) was present. While an interview may provide richer responses, the checklists have the advantage of not potentially distressing the respondent by asking them to recount their experience to a stranger (the researcher) yet another time, as they have most likely had to tell their experience to mental health and law officials already. Overall, these methods have all served to create empirical measures of CSA severity that can allow for comparisons within and between studies and also provide a common language in which to discuss the severity of sexual abuse children experience. In the present study, an empirically validated checklist methodology was used to measure the risk factor of trauma severity in relation to the outcome measures of traumagenic dynamic symptoms and attitudes towards interpersonal relationships in adolescent girls who have been sexually abused.

Domestic Violence

In addition to specific severity of the CSA experienced, experiencing multiple forms of trauma can exacerbate the effects of the abuse (Dong, et al., 2003). A number of studies have concluded that the long-term effects of experiencing child abuse are not just the result of the specific abuse, but that they may be due to the experience of other traumas as well (Bensley, van Eenwyk, & Simmons, 2000; Briere & Runtz, 1990; Brown, Cohen, Johnson, & Smailes, 2000; Mullen, et al., 1996; Walsh, MacMillan, & Jamieson, 2002). Traumas such as domestic violence, parental substance abuse, parental marital discord, and crime in the home frequently co-occur with child abuse (Dong et al., 2003).

It has been suggested that 30-60% of families that experience domestic violence or some kind of child abuse also experience both types of abuse (Appel, & Holden, 1998). Exposure to

domestic violence falls into three categories: Hearing a violent event; Being directly involved as an eyewitness, intervening, or being part of the event (e.g., being used as a shield against an abusive act); Experiencing the aftermath of the abusive event (Edleson, 1999). In addition, some abusers will physically, emotionally, or sexually abuse their children as a way to intimidate and/or control their partner.

Since there can be an interrelationship between the effects of co-occurring traumas, such as CSA and domestic violence, it is necessary to assess for the presence of other traumas along with the severity of the abuse trauma. Domestic violence, specifically, can result in similar behavioral, psychological, and emotional outcomes as CSA, such as anxiety, hostility, increased aggression, poor interpersonal relationships, withdrawal, depression, and low self-esteem (Cohen, et al., 1996). Additionally, adolescents who have been exposed to domestic violence are at higher risk for either perpetrating or becoming victims of teen dating violence (Fantuzzo, et al., 1991). Therefore, in the present study, the risk factor of exposure to domestic violence was assessed in relation to the outcome measures of traumagenic dynamic symptoms and attitudes towards interpersonal relationships in adolescent girls who have been sexually abused. Without this assessment, effects of the abuse may be attributed solely to the CSA or the cumulative effects of multiple traumas may go unassessed (Anda et al., 1999; Dong et al., 2003).

Summary

This chapter presented a critical review of the theoretical and empirical literature related to CSA, its effects on attitudes towards romantic relationships, the protective factors of perception of family support and sense of ethnic identity, and the risk factors of trauma severity and exposure to domestic violence.

While Chapter I reviewed a number of theoretical conceptualizations of CSA, this chapter served to thoroughly explore the traumagenic dynamics theory that conceptualizes CSA. Because this theory was developed specifically to conceptualize the range of symptoms displayed by CSA survivors, and it takes both survivors who experienced single and multiple incidents of CSA into account, the author viewed this model as able to best encompass both the outcome being investigated and the adolescent girls who were participating.

This chapter also provided a review of romantic relationships in adolescent girls. This review examined the nature of romantic relationships in adolescence and the development of violence in these relationships. The relationship between the experience of being abused in childhood and the occurrence of relationship violence was explored through the social learning, attachment, and developmental trauma models. While the findings of research examining this relationship vary, it has been concluded that there is a relationship between childhood abuse and violence both in adolescence and adulthood. Additionally, it has been concluded that there is a relationship between the experience and attitude of acceptance toward relationship violence in adolescence and the experience of relationship violence in adulthood. Based on these findings, the present study aimed to gain a better understanding of the relationship between CSA and attitudes towards romantic relationships in female adolescent CSA survivors in order to inform strategies of intervention and prevention.

Finally, the intervening factors of family support, ethnic identity, trauma severity, and multiple forms of trauma were discussed. An explanation of risk factors and protective factors was provided, and the difference between protective factors and resilience was also reviewed. Family support was discussed as being a protective factor that is a segment of social support that is related to better adjustment in youth. In exploring social support, the main effect and buffering

model hypotheses as well as the defining attributes of social support were reviewed. The specific dimensions of ethnic identity were reviewed in the context of a developmental perspective of this construct. Ethnic identity was explored as a protective factor both in regards to adolescents' general well-being, and the importance it can play as a protective factor in the face of trauma. Trauma severity was explained to be a risk factor for more severe outcomes in CSA survivors; the difficulty in operationalizing and creating a standardized empirical measure for this construct was also reviewed. Lastly, the presence of multiple forms of trauma that co-occur with CSA and the necessity of assessing the cumulative effects of multiple traumas was discussed. Specifically, the interrelated behavioral, psychological, and emotional effects of exposure to domestic violence and experiencing CSA was reviewed because adolescents who have been exposed to domestic violence are at higher risk for either perpetrating or becoming victims of relationship violence (Fantuzzo, et al., 1991).

The literature that has been discussed in this chapter provided support for the idea that CSA can affect later interpersonal functioning in survivors. Through the protective and risk factors that were also reviewed, an understanding of factors that can intervene with the establishment of unhealthy outcomes was presented. This can hopefully provide practitioners working with this population a better understanding of targets for intervention and exploration, and can help them work with their clients towards the prevention of the later development of unhealthy and/or dysfunctional romantic relationships.

CHAPTER III

Methodology

This chapter provides information regarding how study was conducted. First, the study design and the participants, data collection and procedure will be described. Second, the measurement instruments, and the validity and reliability of each instrument, will be reported. Lastly, the hypotheses and statistical analyses will be explained.

Design and Methodology

This study used quasi-experimental approach to collect data. The independent variables of this study were: (a) Traumagenic Dynamic symptoms, which were measured by The Trauma-Related Beliefs Questionnaire (TRB; Hazzard, 1993; see appendix F); (b) Perception of family support, which was measured by The Family Subscale of the Social Support Appraisals Scale of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989; see appendix H); (c) Sense of ethnic identity, which was measured by The Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007; see appendix I); (d) Trauma severity, which was assessed by using the Sexual Abuse Severity Score (Zink, et al., 2009; see appendix J); (e) The presence of current or past domestic violence, which was assessed by having the researcher answer two questions at the end of the Sexual Abuse Severity Score (Zink, et al., 2009) regarding the presence of domestic violence in the participant's records (see appendix J). The dependent variable in this study was attitude towards romantic relationships, which was measured by The Intimate Partner Violence Attitude Scale-Revised (IPVAS-R; Fincham, et al., 2008; see appendix G).

Participants

A sample of 81 females aged 13-18 who had disclosed experiencing CSA was recruited from the Regional Diagnostic and Treatment Center (RDTC) at Newark Beth Israel Medical Center in Newark, New Jersey. The RDTC treats and evaluates children and adolescents who have

been sexually abused. The treatment focuses on providing trauma-related therapy. The evaluations assess the children's psychosocial functioning and inform treatment recommendations. Evaluations are conducted by RDTC clinical staff with the child/adolescent, their legal guardian, and/or their Division of Child Protection & Permanency (DCP&P) caseworker.

The sample size for this study was determined using the statistical software program G*Power (version 3.0; Faul, Erdfelder, Lang, & Buchner, 2007). The assumed values were $\alpha = 0.05$, power = 0.80, and a medium effect size of .30 for bivariate correlations and hierarchical multiple regressions and a medium effect size of .15 for simple regressions. A medium effect size was chosen as to be in accordance with Cohen's (1988) recommendation of doing so in social science research. Effect sizes were determined using Cohen's (1988) recommendations for medium effect size for each of these analyses. The sample size of 81 exceeded the sample size of 77 that power analyses concluded were required for the analyses that follow.

Procedure

Following an adolescent girl's appointment at the RDTC, the primary investigator or a clinician permitted by the hospital and university IRBs asked the legal guardians of the adolescent girls who have experienced CSA if they would consent to their child participating in this study. They were provided with a letter of solicitation explaining the nature of the study (see appendix A), and if they agreed to participate, they were given an informed consent form to review and sign (see appendix C). Following this, the adolescent girl was asked for her assent to participate. The girl was provided with a letter of solicitation for minors (see appendix B), and if she agreed to participate, she was given an assent form to review and sign (see appendix D). All letters of solicitation, consent and assent forms were approved by the hospital and university IRBs. In the consent and assent forms, participants were asked if they would allow the researcher

to obtain information from their files regarding the nature of the sexual abuse they experienced (e.g., age when abused, duration of abuse, number of perpetrators) and if there has ever been an occurrence of domestic violence in their household. This was done so that the participant did not have to complete a self-report asking for this information, which she had already provided to other interviewers prior to and during her evaluation at the RDTC. Granting permission to gather the information in this way kept participants from having to retell this information, which may have been potentially upsetting for them emotionally and psychologically.

The guardians and girls were asked to participate in this study only after their RDTC evaluation was complete. This was because participating in the study beforehand may have interfered with their evaluation by causing discomfort or distress. To additionally reduce the likelihood of distress, any questions specific to the adolescent's abuse were not presented to her but, as mentioned above, were collected using a checklist by the assessor (see Appendix J).

With this population in particular, coercion of any kind needed to be avoided. Therefore, it was made clear to both the guardians and the girls that this study was completely separate from any other services provided at the RDTC (e.g., evaluation, therapy), that this study was voluntary, and they were free to withdraw from the study at any time. Further, they were told that the services they receive at the RDTC would not be affected in any way by their participation or non-participation in the study and that this study was in no way connected to DCP&P. The purpose and nature of the study was explained to all potential participants upon meeting with them. The participants were also offered a five-dollar gift card as compensation for their time.

The participants completed six brief self-report assessments. These assessments were administered to the participants individually. The instruments were as follows: a) Demographic Questionnaire (see appendix E); b) Trauma-Related Beliefs Questionnaire (TRB; Hazzard, 1993;

see appendix F); c) Intimate Partner Violence Attitude Scale-Revised (IPVAS-R; Fincham, et al., 2008; see appendix d); 4) Family Subscale of the Social Support Appraisals Scale of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989; see appendix H); e) Multigroup Ethnic Identity Measure- Revised (MEIM-R; Phinney & Ong, 2007; see appendix I); and f) Sexual Abuse Severity Score (SASS, Zink, et al., 2009; see appendix J). Completion of all the measures took approximately 20-30 minutes.

After completing these assessments participants were debriefed, provided an incentive of a five-dollar gift card, and thanked for their participating in this study. The debriefing entailed discussing the purpose and importance of this study, as well as answering any questions or concerns that the participant had regarding the questionnaires and/or study. Additionally, participants were provided with contact information for any further questions or concerns they may have had. Since this study occurred in a hospital setting where the participants were already receiving services, no additional referral information for counseling was necessary. If a participant had become upset while completing the questionnaires, the assessor (who was also a clinician or a clinician-in-training) would have provided immediate counseling services to the participant. During the course of recruitment, none of the participants became upset or required counseling in relation to their participation in the study. The consent/assent process, the administration of the questionnaires, and the debriefing process were completed by the primary investigator or by RDTC clinicians identified in the hospital and university IRBs as having permission to do so.

Research Instruments

Demographic Questionnaire (see appendix E)

The demographic questionnaire was used to obtain background information for participants in the study. Participants were asked to report age, grade in school, gender, race, ethnicity, primary language spoken at home, religious affiliation, years living in US (if applicable), family composition, household composition, if they live or have lived in a foster home, relationship status, and if they receive or have received therapy. This information was used for purposes of providing descriptive information of the sample and served as variables for which to control, as indicated by correlational analyses with the primary study variables.

Trauma Related Beliefs Questionnaire (TRB: Hazzard, 1993; see appendix F)

The TRB is a 56-item scale developed to assess beliefs that are reflective of Finkelhor and Browne's model (1985) of traumagenic dynamics among individuals who are survivors of sexual abuse. The measure has four subscales, each of which directly corresponds with one of the traumagenic dynamics: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-blame. Items are scored so that higher scores reflect stronger, maladaptive trauma-related beliefs (except for those items which are reverse coded). Each question is rated on a 5-point Likert scale that ranges from 0 ("absolutely untrue") to 4 ("absolutely true"). The mean of all subscale items are computed and these scores can range from 0 to 4. A total TRB score is also computed; this score represents the mean of all the items.

Reliability for this scale was computed with a sample of 56 adult female sexual abuse survivors so that the total TRB scale for this sample had an internal reliability coefficient of .93. The coefficient alpha for the Self-blame/Stigmatization subscale was .89, for the Betrayal subscale it was .86, for the Powerlessness subscale it was .78, and for the Traumatic Sexualization

subscale it was .87 (Hazaard, 1993). Although this measure was normed on an adult population, it has also been used with adolescents. For example, Edwards and Hendrix (2001) used the TRB to explore the traumagenic dynamics model in adolescent male sexual offenders; however, they did not report validation information. Validity of the TRB was assessed by entering TRB scores into multiple regression equations predicting other questionnaire measures of psychological and behavioral symptomatology (Hazaard, 1993). Results of the validation studies were in line with what the authors predicted. The measurement of predictive validity determined that stigmatization beliefs and self-blaming attitudes predicted lower self-esteem (41.9% of variance), more interpersonal problems (45.5% of variance), more depression (7.1% of variance), and greater overall psychological distress (37.9% of variance). Betrayal beliefs were related to interpersonal problems (6.1% of variance), external locus of control (7.9% of variance), and sexual problems. While powerlessness beliefs predicted external locus of control and depression, the percent of variance was not reported (Hazzard, 1993). Internal consistency as measured with Cronbach's Alpha of the TRB for the present sample was calculated to be .85; internal consistency for each of the subscales were as follows: Self-Blame/Stigmatization = .75; Betrayal = .57; Powerlessness = .69; Traumatic Sexualization = .83.

Intimate Partner Violence Attitude Scale-Revised (IPVAS-R; Fincham, et al., 2008; see appendix G)

The IPVAS-R is a 17-item scale addressing attitudes towards dating violence. The IPVAS-R consists of three subscales: (a) Abuse; (b) Control; (c) Violence. Fincham, et al. (2008) completed two reliability and validity studies on the IPVAS-R using university students. Based on factor analysis, they found that the three subscales have reliability coefficients of 0.91, 0.77, and 0.71, respectively. Concurrent validity was determined by correlations between the IPVAS-R and a self-report on constructive conflict behavior and a constructive communication measure.

Predictive validity was examined by finding that abuse, control, and violence attitude scores predicted constructive conflict behavior 14 weeks after initial assessment. Predictive validity was also established by finding that the IPVAS-R was correlated with a measure of relationship satisfaction. Test-retest reliability over a 14-week period was found to be .53 for abuse, .39 for violence, and .58 for control. Discriminant validity was evidenced by the IPVAS-R being unrelated to measures on parental marital satisfaction and the abuse and violence subscales being unrelated to a measure on pro-divorce attitudes (the control subscale was inversely and significantly correlated).

Items on the IPVAS-R are rated on a 5-point Likert-type scale that ranges from 1 (Strongly Disagree) to 5 (Strongly Agree). Lower scores on the violence subscale indicate greater acceptance of violent behavior in one's relationship and higher scores on the abuse and control subscales reflect greater acceptance of abuse, control, in one's relationship. The mean of all subscale items are computed, and these scores can range from 1 to 5. A total IPVAS-R score is also computed; this score represents the mean of all the items. Fincham et al.'s (2009) sample mean for the violence subscale, abuse subscale, and control subscale were 4.56 (SD=.71), 1.59 (SD=.55) and 3.89 (SD=.69), respectively. This study utilized the mean score of the whole scale. Internal consistency as measured with Cronbach's Alpha of the IPVAS for the present sample was calculated to be .788.

Family Subscale of the Social Support Appraisals Scale (APP) of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989; see appendix H)

The SCSS is a measure of supportive behaviors of family member, friends, and classmates. It initially consisted of three scales: The Social Support Appraisals Scale, The Network Scale, and The Scale of Available Behaviors. The author (E. Dubow, personal communication, March 8, 2011) stated that the Network and Available Behaviors Scales are no

longer being used. These scales examined the size of a child's social network and the frequency of supportive behaviors available from a child's support network, respectively. The Social Support Appraisals Scale (APP) examines a child's appraisals of family, teacher, and peer support. As this study is focused specifically on examining the perception of support of non-offending family members, only the family subscale of the APP was used. This subscale is a self-report measure of 12 items in which respondents answer Likert-type questions that range from 1 ("always") to 5 ("never").

Cronbach's alpha tests found the reliability of the SCSS as ranging from .74 to .88 with the reliability of the APP having a Cronbach alpha of .88 and the test-retest reliability being .75 (Dubow & Ullman, 1989). Validity evidence was determined by finding that subscales of the SCSS correlated moderately to highly with corresponding subscales of Harter's (1985) Social Support Measure for Children. As expected, the APP scale correlates higher with its corresponding Harter Social Support subscale than any other Harter Social Support subscale since both assess perceived social support from specific sources (Dubow & Ullman, 1989). The Family Subscale correlated more highly with the parental support subscale ($r = .57$) of Harter's (1985) scale than with Harter's teacher ($r = .18$), classmate, ($r = .32$) or close friend subscales ($r = .23$). Additionally, moderate correlations were found between the APP scale and children's self-esteem, which was stated to be consistent with Cohen and Wills's (1985) statement that networks providing higher levels of esteem support are associated with higher self-esteem in the recipients. Lastly, discriminant validity was displayed when the APP was determined to not be related to peer nominations of aggression, indicating that the SCSS scales and subscales do not just reflect behavioral adjustment or well-being (Dubow & Ullman, 1989). Internal consistency as measured with Cronbach's Alpha of this measure for the present sample was calculated to be .92.

Multigroup Ethnic Identity Measure- Revised (MEIM-R; Phinney & Ong, 2007; see appendix I)

The MEIM-R is a revision of the MEIM (Phinney, 1992) that was designed as a general measure for assessing ethnic identity across diverse ethnic groups, and has been used to also assess ethnic affirmation and exploration (Romero & Roberts, 2003). The original measure included 14 items that assessed the core components of ethnic identity assumed to be common across all ethnic groups: a sense of attachment or belonging, the developmental concept of an achieved identity, and involvement in ethnic practices. This measure was normed on an ethnically diverse population of high school students aged 14-19 (134 Asian American students, 131 African American students, 89 Hispanic students, 41 students with mixed backgrounds, 12 White students, and 10 other), and an ethnically diverse college population aged 18-34 (58 Hispanic students, 35 Asian students, 23 White students, 11 Black students, 8 students of mixed backgrounds, and 1 Native American student).

In response to measurement issues that found discrepancies in whether the MEIM consists of a single factor or of two or more factors, the authors carried out a series of pilot studies. Using exploratory, confirmatory and maximum likelihood factor analyses, a two-factor structure was indicated for a revised measure consisting of six items that load on the two factors, Exploration and Commitment. Items on this scale are responded to using a Likert-type scale that ranges from 1 (“strongly disagree”) to 5 (“strongly agree”). The measure is scored by calculating the mean of the responses given; higher scores indicate a greater sense of one’s ethnic identity.

In regards to validity measurement, the face and content validity of the items were examined with respect to the constructs of interest and the measure was revised so that items were deleted and reworded, and a measure of six items consisting of two subscales, Exploration

(consisting of cognitive and developmental components) and Commitment (consisting of an affective component), was created. Reliability analyses of the two subscales show Cronbach's alphas of .76 for Exploration, .78 for Commitment, and .81 for the total six-item scale. The correlation between the two factors is .74 (Phinney & Ong, 2007). The authors of the scale state that for studies concerned with the overall strength of ethnic identity (such as the present study), the mean of the overall scale can be calculated to obtain a final measure of this construct. Internal consistency as measured with Cronbach's Alpha of this measure for the present sample was calculated to be .81.

Sexual Abuse Severity Score (SASS; Zink, et al., 2009; see appendix J)

To determine the severity of the sexually abusive acts experienced, this study used the SASS, a checklist that examines age at first victimization, number of perpetrators, highest level of coercion, nature of the worst abuse, and number of occurrences of abuse. These factors have all been associated with poor adjustment following abuse (Zink et al., 2009). This measure was selected because although there are many measures assessing the impact of CSA that have been empirically tested, the SASS is the only measure of trauma severity that has been empirically tested. Additionally, the SASS's chart review checklist format allowed for an assessment of trauma severity that minimized the potential distress to adolescents that might result from having to recount details of their abuse to a researcher or interviewer with whom they would have no ongoing therapeutic relationship.

The SASS was developed by questioning 156 respondents who were in three age categories at the time of their abuse: under 14 years old, between 14 and 17 years old, and above 17 years old. Construct and convergent validity were determined by a linear regression model that examined trauma and somatization related to abuse characteristics using the trauma

symptom checklist (Briere & Runtz, 1989). There was a linear relationship with age so that the trauma score decreased by half a point with each year of age. Coercion ($p < .006$) and nature of abuse ($p < .016$) were related to an increase of approximately two points for each severity level. The number of occurrences was linearly related to trauma with approximately a one-point increase for each increase in frequency category. Although the number of perpetrators was not related to trauma or somatic scores, Zink et al. (2009) reported that it was included in the instrument because it was found to be important in other studies. No reliability information on the SASS has been provided, though this checklist was used in the present study because it is the only empirically tested measurement of trauma severity that is available.

Based on the SASS checklist, a summary measure of abuse severity is calculated based on abuse characteristics that are related to poor outcomes and that are rated by professionals as being of greater severity (Briere & Runtz, 1988; Casey & Nurius, 2005; Chaffin, et al., 1997; Kendall-Tackett, et al., 1993). In the present study, for each respondent, the researcher scored the severity level of each of the abuse characteristics examined on the checklist. The resulting summed abuse severity score ranged from 0 to 20, with the higher scores corresponding to a greater severity of abuse experienced by the adolescent.

Statistical Analyses

The following is a list of this study's hypotheses and statistical analysis that were used for each hypothesis:

1. A positive relationship exists between experiencing symptoms of traumagenic dynamics and the endorsement of unhealthy attitudes towards romantic relationships in adolescent females who have experienced CSA, as measured by subjects' composite scores on the TRB and their composite scores on the IPVAS-R.

This hypothesis was analyzed using a bivariate correlational design in which the independent variable was traumagenic dynamic symptomatology and the dependent variable was attitude towards romantic relationships. A power analysis was conducted using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 67 was required.

- 1a. A positive relationship exists between experiencing the traumagenic dynamic symptom of traumatic sexualization and the endorsement of unhealthy attitudes towards romantic relationships in adolescent females who have experienced CSA, as measured by subjects' scores on the Traumatic Sexualization subscale of TRB and their composite scores on the IPVAS-R.

This hypothesis was analyzed using a bivariate correlational design in which the independent variable was the traumagenic dynamic symptom of traumatic sexualization and the dependent variable was attitude towards romantic relationships. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 67 was required.

- 1b. A positive relationship exists between experiencing the traumagenic dynamic symptom of betrayal and the endorsement of unhealthy attitudes towards romantic relationships in adolescent females who have experienced CSA, as measured by subjects' scores on the Betrayal subscale of TRB and their composite scores on the IPVAS-R.

This hypothesis was analyzed using a bivariate correlational design in which the independent variable was the traumagenic dynamic symptom of betrayal and the

dependent variable was attitude towards romantic relationships. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 67 was required.

- 1c. A positive relationship exists between experiencing the traumagenic dynamic symptom of powerlessness and the endorsement of unhealthy attitudes toward romantic relationships in adolescent females who have experienced CSA, as measured by subjects' scores on the Powerlessness subscale of TRB and their composite scores on the IPVAS-R.

This hypothesis was analyzed using a bivariate correlational design in which the independent variable was the traumagenic dynamic symptom of powerlessness and the dependent variable was attitude towards romantic relationships. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 67 was required.

- 1d. A positive relationship exists between experiencing the traumagenic dynamic symptom of stigmatization/self-blame and the endorsement of unhealthy attitudes towards romantic relationships in adolescent females who have experienced CSA, as measured by subjects' scores on the Self-blame/ Stigmatization subscale of TRB and their scores on the IPVAS-R.

This hypothesis was analyzed using a bivariate correlational design in which the independent variable was the traumagenic dynamic symptom of stigmatization/self-blame and the dependent variable was attitude towards romantic relationships. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$,

power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 67 was required.

2. The past or current exposure to domestic violence by adolescent females who have experienced CSA is related to a greater level of traumagenic dynamic symptomatology in adolescent females who have experienced CSA, as measured by chart-review and subjects' composite scores on the TRB.

This hypothesis was analyzed using a bivariate correlation in which the independent variable was exposure to domestic violence and the dependent variable was the traumagenic dynamic symptomatology. A power analysis conducted using G*Power et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 64 was required.

3. Greater trauma severity is predictive of a greater level of traumagenic dynamic symptomatology in adolescent females who have experienced CSA, as measured by subjects' Sexual Abuse Severity Score and their composite scores on the TRB. This hypothesis was analyzed using a simple regression in which the independent variable was the trauma severity and the dependent variable was traumagenic dynamic symptomatology. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .15. The results of the analysis indicated that a sample size of 55 was required.
4. Greater trauma severity is predictive of a greater endorsement of unhealthy attitudes towards romantic relationships by adolescent females who have experienced CSA, as measured by their Sexual Abuse Severity Score and their composite scores on the IPVAS-R.

This hypothesis was analyzed using a simple regression in which the independent variable was the trauma severity and the dependent variable was the attitude towards romantic relationships. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .15. The results of the analysis indicated that a sample size of 55 was required.

5. A positive relationship exists between perceived familial support and sense of ethnic identity in adolescent females who have experienced CSA, as measured by subjects' scores on the SCSS and MEIM-R.

This hypothesis was analyzed using a bivariate correlation in which the independent variable was ethnic identity and the dependent variable was perceived familial support. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .30. The results of the analysis indicated that a sample size of 67 was required.

6. A greater perception of family support and sense of ethnic identity, when controlling for trauma severity and having received therapy, will predict a lower level of traumagenic dynamic symptoms in adolescent females who have experienced CSA, as measured by subjects' Trauma Severity Ratings and their scores on the SCSS, MEIM-R, and composite score on the TRB. Since a higher score on the SCSS indicated lower perceived family support, and a higher score on the MEIM-R indicated greater sense of ethnic identity, it was predicted that higher scores on the SCSS would predict higher scores on the TRB and higher scores on the MEIM-R would predict lower scores on the TRB.

This hypothesis was analyzed using a hierarchical multiple regression in which the independent variables were perceived social support, ethnic identity, trauma severity, and

history of therapy. Trauma severity and therapy were controlled for by being input first into the regression, allowing for the effect of perceived social support and ethnic identity above and beyond the effects of trauma severity and history of therapy to be assessed. Perception of family support was entered as a predictor in step two, and sense of ethnic identity was entered as a predictor in step three. Perception of family support was entered as the first variable because it has been established in the literature as being a protective factor for mental health symptomatology in relation to trauma, and the role of ethnic identity as a protective factor is still being investigated. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .15. The results of the analysis indicated that a sample size of 77 was required.

7. A greater perception of family support and sense of ethnic identity, when controlling for trauma severity and having received therapy, will predict a lower endorsement of unhealthy attitudes towards romantic relationships in adolescent females who have been sexually abused, as measured by subjects' Trauma Severity Ratings and their scores on the SCSS, MEIM-R, and IPVAS-R. Since a higher score on the SCSS indicated lower perceived family support, and a higher score on the MEIM-R indicated greater sense of ethnic identity, it was predicted that higher scores on the SCSS would predict higher scores on the IPVAS-R and higher scores on the MEIM-R would predict lower scores on the IPVAS-R.

This hypothesis was analyzed using a hierarchical multiple regression in which the independent variables were perceived social support, ethnic identity, trauma severity, and history of therapy, and the dependent variable was attitudes toward romantic

relationships. Trauma severity and therapy were controlled for by being input first into the regression, allowing for the effect of perceived social support and ethnic identity above and beyond trauma severity and history of therapy to be assessed. A power analysis was conducted using G*Power (Faul, et al., 2007) with assumed values of $\alpha = 0.05$, power = 0.80, and a medium effect size of .15. The results of the analysis indicated that a sample size of 77 was required.

Summary

This chapter provided methodological information about the proposed study. The design of the study was presented, and the independent and dependent variables, along with their measurement, were delineated. The population of interest and the data collection method were discussed. The instruments that were used in the study were described in detail, and validity and reliability data were reviewed for each scale. Lastly, the hypotheses that were explored in the study were reviewed, and the statistical analyses that were utilized to address each hypothesis were outlined.

CHAPTER IV

Results

The primary purpose of the present study was to use the traumagenic dynamics theoretical conceptualization to examine the attitudes of female adolescent survivors of CSA towards romantic relationships. This study used the theory of traumagenic dynamics to examine how symptomatology resulting from CSA is related to the attitudes adolescent females have towards interpersonal relationships. In examining this relationship, social support and ethnic identity were examined as protective factors against the endorsement of unhealthy attitudes towards romantic relationships, while trauma severity and exposure to domestic violence were examined as risk factors for the endorsement of unhealthy attitudes towards romantic relationships. In this chapter, the design of the study will be reviewed, the procedure for data screening will be presented, the descriptive statistics of the sample will be described, and the findings from each of the tested study hypotheses will be presented and discussed.

Statement of Design

A quasi-experimental approach was used in the present study. The independent variables of this study were: (a) Symptoms of traumagenic dynamics (ie, traumatic sexualization, betrayal, powerlessness, and stigmatization), assessed by The Trauma-Related Beliefs Questionnaire (TRB; Hazzard, 1993); (b) Family support, assessed by The Family Subscale of the Social Support Appraisals Scale of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989); (c) Ethnic identity, assessed by The Multigroup Ethnic Identity Measure – Revised (MEIM-R; Phinney & Ong, 2007); (d) Trauma severity, assessed by the Sexual Abuse Severity Score (Zink, et al., 2009); and (e) The presence of current or past domestic violence, assessed by having the researcher answer two questions at the end of the Sexual Abuse Severity Score (Zink, et al., 2009) regarding the presence of domestic violence in the participant's records. The

dependent variable in this study was the attitude towards romantic relationships, assessed by The Intimate Partner Violence Attitude Scale-Revised (IPVAS-R; Fincham, et al., 2008).

Descriptive Statistics

The present study recruited 81 participants from the Regional Diagnostic and Treatment Center (RDTC) at Newark Beth Israel Medical Center. An a priori power analysis indicated that 77 participants were required to adequately power the study. Participants were all adolescent females (aged 13-18) who had experienced CSA.

Table 1 presents demographic data for the overall sample, which was comprised of females between the ages of 13 and 18. The mean age of participants was 15.01 years. The participants' grade in school at the time of participation ranged from 6th through 12th grade, with a mean of grade 9.18. In regard to racial identity, 37 (45.68%) of the participants identified as Black/African American; 32 (39.51%) identified as Hispanic/Latino; 6 (7.41%) identified as White/Caucasian; 4 (4.94%) identified as Asian; 8 (9.88%) identified as Mixed Race/Mixed Ethnicity; and 2 (2.47%) identified as "other." In regard to language spoken, 59 (72.84%) reported English as their primary language spoken at home; 14 (17.28%) reported Spanish as their primary language spoken at home; 6 (7.41%) reported English and Spanish as their primary languages spoken at home; 2 (2.47%) reported another language primarily spoken at home (i.e. French, Portuguese). In regard to religious affiliation, 47 (58.02%) stated Christian (inclusive of Anglican [n=1], Baptist, [n=1], Catholic [n= 14], Jehovah's Witness [n=1], Mormon, [n=2], Pentecostal [n=2]); 3 (3.70%) stated Muslim; 1 (1.23%) stated Agnostic; 1 (1.23%) stated Atheist; 1 (1.23%) stated Buddhist; 10 (12.35%) stated "none;" and 18 (22.22%) did not answer. In regard to household composition, 8 (9.88%) reported that they live with both their mother and father; 55 (67.90%) reported that they live with their mother and not their father; 3 (3.70%)

reported that they live with their father and not their mother; and 15 (18.52%) reported that they do not live with either their mother or father.

The table further describes household composition of the participants. 69 (85.19%) of the participants have spent their entire life living in the United States. 10 (12.35%) of the participants were in foster care at the time of their participation in the study, and 8 (9.88%) had previously been in foster care. 56 (69.14%) of the participants were in a romantic relationship at the time of participation in the study. In regards to receiving therapy, 29 (35.80%) of the participants had never received therapy; 40 (49.38%) reported that they were receiving therapy at the time of their participation in the study; 20 (24.69%) reported that they had received therapy prior to participating in the study. Totals of therapy participation add up to greater than 100% because some participants receiving therapy at the time of their participation in the study also had received therapy in the past.

Table 1
Demographic Characteristics of the Sample (n=81)

| | <i>M</i> | <i>f</i> | <i>%</i> |
|----------------------------------|----------|----------|----------|
| Participant Age | 15.01 | - | - |
| Participant Grade | 9.18 | - | - |
| Race/Ethnicity | | | |
| Black/African American | - | 37 | 45.68 |
| Hispanic/Latino | - | 32 | 39.51 |
| White/Caucasian | - | 6 | 7.41 |
| Asian | - | 4 | 4.94 |
| Mixed Race/Mixed Ethnicity | - | 8 | 9.88 |
| Other | - | 2 | 2.47 |
| Primary Language Spoken at home | | | |
| English | - | 59 | 72.84 |
| Spanish | - | 14 | 17.28 |
| English and Spanish | - | 6 | 7.41 |
| Other | - | 2 | 2.47 |
| Religious Affiliation | | | |
| Christian | - | 47 | 58.02 |
| Muslim | - | 3 | 3.70 |
| Agnostic | - | 1 | 1.23 |
| Atheist | - | 1 | 1.23 |
| Buddhist | - | 1 | 1.23 |
| None | - | 10 | 12.35 |
| No Response | - | 18 | 22.22 |
| Household Composition | | | |
| Mother | - | 63 | 77.78 |
| Father | - | 11 | 13.58 |
| Stepmother | - | 1 | 1.23 |
| Stepfather | - | 18 | 22.22 |
| Brother(s) | - | 49 | 60.49 |
| Sister(s) | - | 36 | 44.44 |
| Stepbrother(s) | - | 1 | 1.23 |
| Stepsister(s) | - | 2 | 2.47 |
| Grandmother | - | 18 | 22.22 |
| Grandfather | - | 5 | 6.17 |
| Aunt(s) | - | 11 | 13.58 |
| Uncle(s) | - | 5 | 6.17 |
| Parent's significant other | - | 2 | 2.47 |
| Other (e.g., cousins, unrelated) | - | 6 | 7.41 |
| Time Living in United States | | | |
| Entire Life | - | 69 | 85.19 |
| Immigrated to United States | - | 12 | 14.81 |
| Foster Care | | | |
| Never in Foster Care | | 63 | 77.78 |

| | | | |
|------------------------------|---|----|-------|
| Current Foster Care | - | 10 | 12.35 |
| Past Foster Care | - | 8 | 9.88 |
| Romantic Relationship Status | | | |
| In a Relationship | - | 56 | 69.14 |
| Single | - | 25 | 30.86 |
| Therapy Experience | | | |
| Never | - | 29 | 35.80 |
| Currently in Therapy | - | 40 | 49.38 |
| Prior Therapy | - | 20 | 24.69 |

Preliminary Analyses

Preliminary analyses to screen the data were performed using SPSS Explore. To reduce kurtosis and improve normality, linearity, and homoscedasticity, the following variables were transformed using a base-10 logarithm: The traumagenic dynamic of self-blame/stigmatization, and the SCSS score. Subsequent analysis of the transformed variables revealed acceptable levels of skewness and kurtosis.

Primary Study Variables

Prior to conducting inferential statistics, descriptive statistics for this study's primary variables were obtained. These statistics are displayed in Table 2.

Traumagenic Dynamic Symptoms

Participants' experiences of traumagenic dynamics were measured by the Trauma Related Beliefs Questionnaire (TRB: Hazzard, 1993). An overall mean was calculated, as well as means of each of the four subscales,: (a).Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame. Items on the TRB were rated on a 5-point Likert-type scale that ranged from 0 ("absolutely untrue") to 4 ("absolutely true"). Mean scores of the overall TRB and each subscale were calculated. Higher scores indicated higher levels of traumagenic dynamics. Means and standard deviations for the sample are provided in Table 2.

Attitudes toward Romantic Relationships

Participants' attitudes toward dating were measured by the Intimate Partner Violence Attitude Scale-Revised (IPVAS-R; Fincham, Cui, Braithwaite, and Pasley, 2008). Items on the IPVAS-R were rated on a 5-point Likert-type scale that ranged from 1 ("strongly disagree") to 5 ("strongly agree"). The mean score of the IPVAS-R was calculated. Higher scores indicated a greater endorsement of unhealthy attitude towards dating, signifying the endorsement of physical, sexual, emotional or psychological aggression in romantic relationships. Means and standard deviations for the sample are provided in Table 2.

Perception of Family Support

Participants' perceptions of family support received were measured by the Family Subscale of the Social Support Appraisals Scale (APP) of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989). Items on this subscale were rated on a 5-point Likert-type scale that ranged from 1 ("always") to 5 ("never"). Higher scores indicated lower perception of familial support. Means and standard deviations for the sample are provided in Table 2.

Sense of Ethnic Identity

Participants' senses of their ethnic identity were measured by the Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007). Items on the scale were rated on a 5-point Likert-type scale that ranged from 1 ("strongly disagree") to 5 ("strongly agree"). Higher scores indicated one having a greater sense of her ethnic identity. Means and standard deviations for the sample are provided in Table 2.

Trauma Severity

The severity of the sexual abuse experienced by the participant was assessed by the Sexual Abuse Severity Score (SASS; Zink, Klesges, Stevens & Decker, 2009). The SASS is a

checklist that records participants' age at first victimization, number of perpetrators, highest level of coercion, nature of the worst abuse, and number of occurrences of abuse. Items on the checklist were summed, and the resulting summed abuse severity score ranged from 0 to 20. Higher scores indicated a greater severity of abuse experienced. Means and standard deviations for the sample are provided in Table 2.

Exposure to Domestic Violence

Participants' exposure to domestic violence was measured by a chart review to determine if the participant was currently or had been previously exposed to domestic violence in their household. Means and standard deviations for the sample are provided in Table 2.

Table 2
Descriptive Statistics for Primary Variables

| | <i>M</i> | <i>SD</i> |
|---------------------------------|----------|-----------|
| Traumagenic Dynamics | 1.59 | 0.44 |
| Traumatic Sexualization | 1.43 | 0.91 |
| Betrayal | 1.94 | 0.58 |
| Powerlessness | 1.60 | 0.69 |
| Stigmatization/Self-Blame | 1.52 | 0.49 |
| Stigmatization/Self-Blame (LOG) | 0.16 | 0.14 |
| Attitudes towards Dating | 2.12 | 0.61 |
| Family Support | 2.41 | 0.88 |
| Family Support (LOG) | 0.36 | 0.16 |
| Ethnic Identity | 3.31 | 0.78 |
| Trauma Severity | 9.46 | 4.60 |
| Presence of Domestic Violence | 0.33 | .474 |
| Currently | 0.09 | .283 |
| Past | 0.33 | .474 |

Bivariate correlations between the primary study variables and pertinent demographic variables were conducted to determine which variables needed to be controlled for when completing inferential statistics. Trauma severity was correlated with overall traumagenic dynamics, the specific traumagenic dynamics of betrayal, stigmatization/self-blame, and powerlessness, and with perception of familial support; it was controlled for in the relevant analyses. Additionally, therapy was correlated with attitudes towards romantic relationships and with perception of familial support; it was controlled for in relevant analyses. The results of these correlational analyses are presented in Table 3.

Table 3
Bivariate Correlations between Primary Variables

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|------------------------------------|---|---|---|---|---|------|----------|------------|---------|--------------|--------|
| 1. Traumagenic Dynamics | - | - | - | - | - | .193 | .335*** | -.168 | .275** | .151 | .085 |
| 2. Traumatic Sexualization | | - | - | - | - | .199 | -.048 | .003 | -.153 | .135 | -.192 |
| 3. Betrayal | | | - | - | - | .046 | .370**** | - .258* | .288*** | -.011 | .221 |
| 4. Powerlessness | | | | - | - | .163 | .249* | -.096 | .228* | .080 | .098 |
| 5. Stigmatization/Self-blame (LOG) | | | | | - | .144 | .332*** | -.136 | .307*** | -.017 | .190 |
| 6. Attitudes towards Dating | | | | | | - | .279**** | -.210 | .111 | .033 | -.234* |
| 7. Family Support (LOG) | | | | | | | - | -.148 | .345*** | -.017 | .238* |
| 8. Ethnic Identity | | | | | | | | - | -.126 | - .365*** | -.122 |
| 9. Trauma Severity | | | | | | | | | - | -.126 | .080 |
| 10. Domestic Violence | | | | | | | | | | - | .146 |
| 11. Therapy | | | | | | | | | | | - |

* $p < .05$; ** $p < .01$; *** $p < .005$; **** $p < .001$

Hypothesis Testing

Hypothesis 1

This hypothesis predicted that within the recruited sample, a positive relationship existed between experiencing symptoms of traumagenic dynamics and endorsing unhealthy attitudes towards romantic relationships. Based on the bivariate correlations among study variables that were described above, trauma severity and therapy were controlled for in this analysis.

Hypothesis 1a-1d

In addition to predicting a positive relationship between overall traumagenic dynamic symptoms and unhealthy attitudes towards romantic relationships, it was predicted that there was a positive relationship between each of the four specific traumagenic dynamic symptoms: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame (analyzed using base-10 logarithm: stigmatization/self-blame LOG) and attitudes toward romantic relationships. To explore these hypotheses, a bivariate correlation was used. Based on the bivariate correlations among study variables that were described above, trauma severity and therapy were controlled for in these analyses.

This study did not find support for hypothesis one. There was not a significant correlation between overall traumagenic dynamic symptoms and unhealthy attitudes towards romantic relationships, $r = .192$, $p = .090$ (Table 4).

This study did not find support for hypothesis 1a. There was not a significant correlation between the traumagenic dynamic symptom of traumatic sexualization and unhealthy attitudes towards romantic relationships, $r = .184$, $p = .105$ (Table 4).

This study did not find support for hypothesis 1b. There was not a significant correlation between the traumagenic dynamic symptom of betrayal and unhealthy attitudes towards romantic relationships, $r = .070$, $p = .543$ (Table 4).

This study did not find support for hypothesis 1c. There was not a significant correlation between the traumagenic dynamic symptom of powerlessness and unhealthy attitudes towards romantic relationships, $r = .168$, $p = .139$ (Table 4).

This study did not find support for hypothesis 1d. There was not a significant correlation between the traumagenic dynamic symptom of stigmatization/self-blame using stigmatization/self-blame LOG and unhealthy attitudes towards romantic relationships, $r = .152$, $p = .182$ (Table 4).

Table 4

Bivariate Correlations between TD and Unhealthy Attitudes toward Relationships

Unhealthy Attitudes toward Relationships

| | |
|---------------------------------|------|
| Overall TD* | .192 |
| Traumatic Sexualization | .184 |
| Betrayal | .070 |
| Powerlessness | .168 |
| Stigmatization/Self-blame (LOG) | .152 |

Note: TD refers to Traumagenic Dynamic Symptomatology

Hypothesis 2

This hypothesis predicted that within the recruited sample, a positive relationship existed between exposure to domestic violence and experiencing traumagenic dynamic symptomatology. To explore this hypothesis, a bivariate correlation was used.

This study did not find support for hypothesis 2. There was not a significant correlation between participants' exposure to domestic violence and the level of their traumagenic dynamic symptomatology, $r = .194$, $p = .082$ (Table 5).

As a follow-up, analyses were completed to examine whether within the recruited sample, a positive relationship existed between exposure to domestic violence and experiencing each of the traumagenic dynamic symptoms: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame (analyzed using base-10 logarithm: stigmatization/self-blame LOG). To explore these hypotheses, four bivariate correlations were used. The study did not find support for a positive relationship between any of the traumagenic dynamic symptoms and exposure to domestic violence. The following are the non-significant findings of the correlations: traumatic sexualization and exposure to domestic violence, $r = .011$, $p = .923$; betrayal and exposure to domestic violence, $r = .135$, $p = .228$; powerlessness and exposure to domestic violence, $r = .080$, $p = .475$; stigmatization/self-blame LOG and exposure to domestic violence, $r = .151$, $p = .178$ (Table 5).

Table 5

Bivariate Correlations between Exposure to Domestic Violence and TD

| | Unhealthy Attitudes toward Relationships |
|---------------------------------|--|
| Overall TD | .194 |
| Traumatic Sexualization | .011 |
| Betrayal | .135 |
| Powerlessness | .080 |
| Stigmatization/Self-blame (LOG) | .151 |

Note: TD refers to Traumagenic Dynamic Symptomatology

Hypothesis 3

This hypothesis predicted that within the recruited sample, greater trauma severity was predictive of a greater level of traumagenic dynamic symptoms. To explore this hypothesis, a simple regression analysis was used.

This study found support for hypothesis 3. Table 6 displays the unstandardized regression coefficient (B) and the standardized regression coefficients, (β), R , R^2 , and F after entry of all variables. R^2 was significantly different from zero. The total R^2 was .075, $F(1,79) = 6.44$, $p = .01$. The adjusted R^2 value of .064 suggests that 64% of the variance in traumagenic dynamics was predicted by trauma severity and made a statistically significant contribution to the variability in traumagenic dynamics ($\beta = .275$, $p = .01$).

As a follow-up, analyses were completed to examine whether within the recruited sample, greater trauma severity was predictive of a greater level of each of the traumagenic dynamic symptoms: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame (analyzed using base-10 logarithm: stigmatization/self-blame LOG). This was explored using simple regressions. The study found support for trauma severity significantly predicted the traumagenic dynamic symptoms of betrayal ($\beta = .288$, $p = .016$), powerlessness ($\beta = .228$, $p = .041$), and stigmatization/self-blame ($\beta = -.228$, $p = .005$). The study did not find support for trauma severity significantly predicting the traumagenic dynamic symptoms of traumatic sexualization ($\beta = -.153$, $p = .171$). The unstandardized regression coefficient (B) and the standardized regression coefficients, (β), R , R^2 , and F for each traumagenic dynamic's relationship with trauma severity are reported in Table 6.

Table 6

Summary of Regression Analysis Predicting Traumagenic Dynamic Symptoms from SASS

| | B | β | R ² | Adjusted R ² | F |
|-------------------|-------|---------|----------------|-------------------------|---------|
| TD | .026 | .275** | .075 | .064 | 6.44** |
| TS | -.031 | -.153 | .024 | .011 | 1.91 |
| Betrayal | .037 | .288*** | .083 | .071 | 7.15*** |
| Powerlessness | -0.34 | .228* | .052 | .040 | 4.33* |
| Stigma/Self-Blame | 9.95 | .307*** | .094 | .083 | 8.22*** |

Note: TD refers to Traumagenic Dynamic Symptomatology; TS refers to Traumatic Sexualization; * $p \leq .05$; ** $p \leq .01$; *** $p \leq .005$

Hypothesis 4

This hypothesis predicted that within the recruited sample, greater trauma severity was predictive of a higher endorsement of unhealthy attitudes towards romantic relationships. To explore this hypothesis, a simple regression was used.

This study did not find support for hypothesis 4. Table 7 displays the unstandardized regression coefficient (B) and the standardized regression coefficients, (β), R , R^2 , and F after entry of all variables. R was significantly different from zero. The total R^2 was .012, $F(1,79) = .987$, $p = .324$. The adjusted R^2 value of .000 suggests that none of the variance in attitudes towards romantic relationships was predicted by trauma severity and did not made a statistically significant contribution to the variability in attitudes towards romantic relationships ($\beta = .111$).

Table 7

Summary of Regression Analysis Predicting Unhealthy Attitudes toward Romantic Relationships

| | B | β | R ² | Adjusted R ² | F |
|-------------------|------|---------|----------------|-------------------------|------|
| Severity of Abuse | .015 | .111 | .012 | .000 | .987 |

Hypothesis 5

This hypothesis predicted that within the recruited sample, a positive relationship existed between perceived family support and sense of ethnic identity. To explore this hypothesis, a bivariate correlation was used.

This study did not find support for hypothesis 5. There was not a significant correlation between family support and sense of ethnic identity ($r = -.148, p = .188$).

Hypothesis 6

This hypothesis predicted that within the recruited sample, a greater perception of family support and sense of ethnic identity, when controlling for trauma severity and having received therapy, would predict a lower level of traumagenic dynamic symptoms. Trauma severity and having received therapy were controlled for because they were significantly correlated with perception of family support. To explore this hypothesis, a hierarchical multiple regression was used.

Table 8 illustrates the unstandardized regression coefficients (B), the standardized regression coefficients (β), R , R^2 , F , and F change after entry of all variables. R was significantly different from zero after both steps of the analysis. In step one, trauma severity and having had treatment explained approximately 8% of the variance in traumagenic dynamic symptoms ($R^2 = .079$, adjusted $R^2 = .056$, $F(2,78) = 3.36$, $p = .040$). In step two, perception of family support explained approximately 6% of the additional variance in traumagenic dynamic symptoms when controlling for trauma severity and having had treatment (R^2 change = .062, adjusted $R^2 = .108$, $F(3,77) = 4.22$, $p = .008$). In step three, sense of ethnic identity explained approximately 1% of the additional variance (R^2 change = .011). The total variance explained by the model was 10% (adjusted $R^2 = .108$, $F(4,76) = 3.42$, $p = .01$). In the final model, one variable was statistically

significant: perception of family support ($\beta = .261, p = .027$). The variables of trauma severity ($\beta = .171, p = .134$), having had treatment ($\beta = -.004, p = .972$) and sense of ethnic identity ($\beta = .109, p = .316$) were not statistically significant.

Table 8
Summary of Hierarchical Regression Analysis Predicting Traumagenic Dynamics

| Variable | B | β | R | R ² | Adjusted R ² | R ² Change | F | F Change |
|------------------------------|-------|---------|------|----------------|-------------------------|-----------------------|--------------|----------|
| Step 1 | | | .282 | .079 | .056 | | $F = 3.36^*$ | |
| Trauma Severity | .026 | .269* | | | | | | |
| Therapy Experience | .058 | .064 | | | | | | |
| Step 2 | | | .376 | .141 | .108 | .062 | 4.22** | 5.54* |
| Trauma Severity | .017 | .180 | | | | | | |
| Therapy Experience | .006 | .006 | | | | | | |
| Perception of Family Support | .725 | .272* | | | | | | |
| Step 3 | | | .391 | .153 | .108 | .011 | 3.42* | 1.02 |
| Trauma Severity | .016 | .171 | | | | | | |
| Therapy Experience | -.004 | -.004 | | | | | | |
| Perception of Family Support | .697 | .261* | | | | | | |
| Sense of Ethnic Identity | -.061 | -.109 | | | | | | |

* $p < .05$; ** $p \leq .01$

As a follow-up, analyses were completed to examine if within the recruited sample, when controlling for trauma severity and receiving therapy, the perception of family support and sense of ethnic identity would predict the presence of each of the traumagenic dynamic symptoms: (a) Traumatic Sexualization, (b) Betrayal, (c) Powerlessness, and (d) Stigmatization. To explore these hypotheses, four hierarchical multiple regressions were used.

Hypothesis 6a

Table 9 illustrates the unstandardized regression coefficients (B), the standardized regression coefficients (β), R , R^2 , F , and F change after entry of all variables. R was significantly different from zero after both steps of the analysis. In step one of the regression model, trauma severity and having had treatment explained approximately 6% of the variance in traumatic sexualization symptoms ($R^2 = .056$, adjusted $R^2 = .032$, $F(2,78) = 2.31$, $p = .106$). In step two, perceived social support explained approximately .02% of the additional variance in traumatic sexualization symptoms when controlling for trauma severity and having had treatment (R^2 change = .002, adjusted $R^2 = .021$, $F(3,77) = 1.58$, $p = .201$). In step three, sense of ethnic identity explained approximately .01% of the additional variance (R^2 change = .001). The total variance explained by the model was .1% (adjusted $R^2 = .010$, $F(4,76) = 1.20$, $p = .320$). In the final model, none of the variables were statistically significant: trauma severity ($\beta = -.158$, $p = .187$), having had treatment ($\beta = -.194$, $p = .095$); perception of social support ($\beta = .047$, $p = .699$); or sense of ethnic identity ($\beta = -.034$, $p = .301$).

Table 9

Summary of Hierarchical Regression Analysis Predicting Traumagenic Dynamic of Traumatic Sexualization

| Variable | B | β | R | R ² | Adjusted R ² | R ² Change | F | F Change |
|------------------------------|-------|---------|------|----------------|-------------------------|-----------------------|------|----------|
| Step 1 | | | .236 | .056 | .032 | | 2.31 | |
| Trauma Severity | -.342 | -.139 | | | | | | |
| Therapy Experience | -.028 | -.180 | | | | | | |
| Step 2 | | | .241 | .058 | .021 | .002 | 1.58 | .176 |
| Trauma Severity | -.031 | -.156 | | | | | | |
| Therapy Experience | -.363 | -.191 | | | | | | |
| Perception of Family Support | .282 | .051 | | | | | | |
| Step 3 | | | .243 | .59 | .010 | .001 | 1.20 | .091 |
| Trauma Severity | -.032 | -.158 | | | | | | |
| Therapy Experience | -.369 | -.194 | | | | | | |
| Perception of Family Support | .263 | .047 | | | | | | |
| Sense of Ethnic Identity | -.040 | -.034 | | | | | | |

Hypothesis 6b

Table 10 illustrates the unstandardized regression coefficients (B), the standardized regression coefficients (β), R , R^2 , F , and p change after entry of all variables. R was significantly different from zero after both steps of the analysis. In step one of the regression model, trauma severity and having had treatment explained approximately 12% of the variance in betrayal symptoms ($R^2 = .122$, adjusted $R^2 = .100$, $F(2,78) = 5.44$, $p = .006$). In step two, perceived social support explained approximately 6% of the additional variance in betrayal symptoms when controlling for trauma severity and having had treatment (R^2 change = .062, adjusted $R^2 = .153$, $F(3,77) = 5.82$, $p = .001$). In step three, sense of ethnic identity explained approximately 3% of the additional variance (R^2 change = .033). The total variance explained by the model was 17% (adjusted $R^2 = .176$, $F(4,76) = 5.28$, $p = .001$). In the final model, one variable was statistically significant: Perception of social support ($\beta = .255$, $p = .025$). The variables of trauma severity ($\beta = .167$, $p = .128$), having had treatment ($\beta = .124$, $p = .239$) and sense of ethnic identity ($\beta = -.184$, $p = .079$) were not statistically significant.

Table 10

Summary of Hierarchical Regression Analysis Predicting Traumagenic Dynamic of Betrayal

| Variable | B | β | R | R ² | Adjusted R ² | R ² Change | F | F Change |
|------------------------------|-------|---------|------|----------------|-------------------------|-----------------------|---------|----------|
| Step 1 | | | .350 | .122 | .100 | | 5.44** | |
| Trauma Severity | .035 | .272** | | | | | | |
| Therapy Experience | .241 | .199 | | | | | | |
| Step 2 | | | .430 | .185 | .153 | .062 | 5.82*** | 5.89* |
| Trauma Severity | .023 | .183 | | | | | | |
| Therapy Experience | .171 | .141 | | | | | | |
| Perception of Family Support | .968 | .273* | | | | | | |
| Step 3 | | | .466 | .217 | .176 | .033 | 5.28*** | 3.17 |
| Trauma Severity | .021 | .167 | | | | | | |
| Therapy Experience | .151 | .124 | | | | | | |
| Perception of Family Support | .905 | .255* | | | | | | |
| Sense of Ethnic Identity | -.137 | -.184 | | | | | | |

* $p < .05$; ** $p \leq .01$; *** $p \leq .001$

Hypothesis 6c

Table 11 illustrates the unstandardized regression coefficients (B), the standardized regression coefficients (β), R , R^2 , F , and F change after entry of all variables. R was significantly different from zero after both steps of the analysis. In step one of the regression model, trauma severity and having had treatment explained approximately 6% of the variance in powerlessness symptoms ($R^2 = .058$, adjusted $R^2 = .34$, $F(2,78) = 2.42$, $p = .096$). In step two, perceived social support explained approximately 3% of the additional variance in powerlessness symptoms when controlling for trauma severity and having had treatment (R^2 change = .028, adjusted $R^2 = .051$, $F(3,77) = 2.44$, $p = .071$). In step three, sense of ethnic identity explained .02% of the additional variance (R^2 change = .002). The total variance explained by the model was approximately 4% (adjusted $R^2 = .041$, $F(4,76) = 1.85$, $p = .129$). In the final model, none of the variables were statistically significant: trauma severity ($\beta = .157$, $p = .183$); having had treatment ($\beta = .037$, $p = .744$); perception of social support ($\beta = .180$, $p = .139$); or sense of ethnic identity ($\beta = -.045$, $p = .691$).

Table 11

Summary of Hierarchical Regression Analysis Predicting Traumagenic Dynamic of Powerlessness

| Variable | B | β | R | R ² | Adjusted R ² | R ² Change | F | F Change |
|------------------------------------|-------|---------|------|----------------|----------------------------|--------------------------|------|-------------|
| Step 1 | | | .242 | .058 | .034 | | 2.42 | |
| Trauma Severity | .033 | .222 | | | | | | |
| Therapy Experience | .114 | .080 | | | | | | |
| Step 2 | | | .294 | .087 | .051 | .028 | 2.44 | 2.39 |
| Trauma Severity | .024 | .161 | | | | | | |
| Therapy Experience | .059 | .041 | | | | | | |
| Perception of Family Support | .769 | .184 | | | | | | |
| Step 3 | | | .298 | .89 | .041 | .002 | 1.85 | .160 |
| Trauma Severity | .024 | .157 | | | | | | |
| Therapy Experience | .053 | .037 | | | | | | |
| Perception of Family Support | .751 | .180 | | | | | | |
| Sense of Ethnic Identity | -.039 | -.045 | | | | | | |

Hypothesis 6d

Table 12 illustrates the unstandardized regression coefficients (B), the standardized regression coefficients (β), R , R^2 , F , and F change after entry of all variables. R was significantly different from zero after both steps of the analysis. In step one of the regression model, trauma severity and having had treatment explained approximately 10% of the variance in self-blame/stigmatization symptoms ($R^2 = .108$, adjusted $R^2 = .085$, $F(2,78) = 4.72$, $p = .012$). In step two, perceived social support explained approximately 4% of the additional variance in traumagenic dynamic symptoms when controlling for trauma severity and having had treatment (R^2 change = .044, adjusted $R^2 = .119$, $F(3,77) = 4.60$, $p = .005$). In step three, sense of ethnic identity explained .04% of the additional variance (R^2 change = .004). The total variance explained by the model was approximately 11% (adjusted $R^2 = .112$, $F(4,76) = 3.52$, $p = .011$). In the final model, none of the variables were statistically significant: trauma severity ($\beta = .217$, $p = .058$); having had treatment ($\beta = .062$, $p = .569$); perception of social support ($\beta = .222$, $p = .058$); or sense of ethnic identity ($\beta = -.068$, $p = .529$).

Table 12

Summary of Hierarchical Regression Analysis Predicting Traumagenic Dynamic of Self-Blame/Stigmatization

| Variable | B | β | R | R ² | Adjusted R ² | R ² Change | F | F Change |
|------------------------------|-------|---------|------|----------------|-------------------------|-----------------------|---------|----------|
| Step 1 | | | .328 | .108 | .085 | | 4.72** | |
| Trauma Severity | .009 | .298** | | | | | | |
| Therapy Experience | .034 | .117 | | | | | | |
| Step 2 | | | .390 | .152 | .119 | .044 | 4.60*** | 3.98* |
| Trauma Severity | .007 | .223* | | | | | | |
| Therapy Experience | .020 | .069 | | | | | | |
| Perception of Family Support | .197 | .229* | | | | | | |
| Step 3 | | | .395 | .156 | .112 | .004 | 3.52** | .400 |
| Trauma Severity | .007 | .217 | | | | | | |
| Therapy Experience | .018 | .062 | | | | | | |
| Perception of Family Support | .192 | .222 | | | | | | |
| Sense of Ethnic Identity | -.012 | -.068 | | | | | | |

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .005$

Hypothesis 7

This hypothesis predicted that within the recruited sample, a greater perception of family support and sense of ethnic identity, when controlling for trauma severity and having received therapy, would predict a lower endorsement of unhealthy attitudes towards romantic relationships. Trauma severity and having received therapy were controlled for because they were significantly correlated with perception of family support. To explore this hypothesis, a hierarchical multiple regression was used.

Table 9 illustrates the unstandardized regression coefficients (B), the standardized regression coefficients (β), R , R^2 , F , and F change after entry of all variables. R was significantly different from zero after both steps of the analysis. In step one, trauma severity and having had treatment explained approximately 7% of the variance in unhealthy attitudes towards dating ($R^2 = .072$, adjusted $R^2 = .048$, $F(2,78) = 3.02$, $p = .054$). In step two, perception of family support explained approximately 10% of the additional variance in unhealthy attitudes towards dating when controlling for trauma severity and having had treatment (R^2 change = .102, adjusted $R^2 = .142$, $F(3,77) = 5.40$, $p = .002$). In step three, sense of ethnic identity explained approximately 4% of the additional variance (R^2 change = .040). The total variance explained by the model was 17% (adjusted $R^2 = .172$, $F(4,76) = 5.16$, $p = .001$). In the final model, three variables were statistically significant with two variables having significant inverse relationships with unhealthy attitudes towards romantic relationships: having had treatment ($\beta = -.338$, $p = .002$); and sense of ethnic identity ($\beta = -.203$, $p = .003$). One variable had a positive significant relationship with unhealthy attitudes towards romantic relationships: the measure for perception of family support ($\beta = .329$, $p = .004$). The measure for the variable of perception of family support was scored so that higher scores indicated less perceived support. Therefore, this finding indicates that greater

perception of family support and higher sense of ethnic identity are related to lower endorsement of unhealthy attitudes towards romantic relationships. The variable of trauma severity ($\beta = -.001$, $p = .058$) was not statistically significant .

Table 13
Summary of Hierarchical Regression Analysis Predicting Unhealthy Attitudes towards Romantic Relationships

| Variable | B | β | R | R ² | Adjusted R ² | R ² Change | F | F Change |
|------------------------------|-------|----------|------|----------------|-------------------------|-----------------------|---------|----------|
| Step 1 | | | .268 | .072 | .048 | | 3.02* | |
| Trauma Severity | .017 | .131 | | | | | | |
| Therapy Experience | -.307 | -2.238* | | | | | | |
| Step 2 | | | .417 | .174 | .142 | .102 | 5.40*** | 9.49*** |
| Trauma Severity | .002 | .016 | | | | | | |
| Therapy Experience | -.400 | -.319*** | | | | | | |
| Perception of Family Support | 1.28 | .349*** | | | | | | |
| Step 3 | | | .462 | .214 | .172 | .040 | 5.16*** | 3.85* |
| Trauma Severity | .000 | -.001 | | | | | | |
| Therapy Experience | -.423 | -.338*** | | | | | | |
| Perception of Family Support | 1.21 | .329*** | | | | | | |
| Sense of Ethnic Identity | -.157 | -.203* | | | | | | |

* $p < .05$; ** $p \leq .01$; *** $p \leq .001$

Summary

The results of the statistical analyses provided partial support for the study's hypotheses. First, it was hypothesized that within the recruited sample, a positive relationship existed between experiencing symptoms of traumagenic dynamics and the endorsement of unhealthy attitudes towards romantic relationships.

The results of a bivariate correlation indicated that there was not a relationship between an overall experience of traumagenic dynamic symptoms and the endorsement of unhealthy attitudes towards romantic relationships. Additionally, no relationship was found between each of the specific traumagenic dynamic symptoms – (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/ Self-Blame – and the endorsement of unhealthy attitudes towards romantic relationships. Thus, hypotheses 1, 1a, 1b, 1c, and 1d were not supported.

The second hypothesis proposed that within the recruited sample, exposure to domestic violence would be related to a greater level of traumagenic dynamic symptomatology. The results of a bivariate correlation indicated there was not a relationship between ever being exposed to domestic violence and experiencing traumagenic dynamic symptoms. Thus, hypothesis 2 was not supported. A follow-up analysis found that there was no relationship between exposure to domestic violence and any of the specific traumagenic dynamic symptoms of traumatic sexualization, betrayal, powerlessness, or stigmatization/self-blame.

The third hypothesis predicted that within the recruited sample, greater trauma severity would be predictive of a greater level of traumagenic dynamic symptoms. The results of a simple regression analysis indicated that the severity of sexual abuse predicted greater traumagenic dynamic symptoms. Thus, hypothesis three was supported. A follow-up analysis found that severity of sexual abuse also predicted the traumagenic dynamic symptoms of betrayal,

powerlessness, and stigmatization/self-blame, but did not find support for trauma severity significantly predicting the traumagenic dynamic symptom of traumatic sexualization.

The fourth hypothesis predicted that within the recruited sample, greater trauma severity is predictive of a higher endorsement of unhealthy attitudes towards romantic relationships. The results of a simple regression analysis indicated that the severity of sexual abuse did not predict the unhealthy attitudes towards romantic relationships. Thus, hypothesis 4 was not supported.

The fifth hypothesis predicted that within the recruited sample, a positive relationship existed between the perception of family support and sense of ethnic identity. The results of a bivariate correlation indicated that there was not a relationship between perception of family support and sense of ethnic identity. Thus, hypothesis 5 was not supported.

The sixth hypothesis predicted that within the recruited sample, when controlling for trauma severity and having received therapy, a greater perception of family support and sense of ethnic identity would predict a lower level of traumagenic dynamic symptoms. A hierarchical regression analysis found that the perception of family support accounted for approximately 6% of the variation in traumagenic dynamic symptoms over and above trauma severity and having received treatment, and that sense of ethnic identity accounted for approximately 1% of the variation in traumagenic dynamic symptomatology over and above trauma severity, having received treatment, and perceptions of family support. Perception of family support was a significant predictor of traumagenic dynamic symptoms; ethnic identity was not a significant predictor of traumagenic dynamic symptoms. Thus, hypothesis 6 was partially supported.

As a follow-up, analyses were completed to examine whether within the recruited sample, when controlling for trauma severity and receiving therapy, the perception of family support and sense of ethnic identity would predict the presence of each of the traumagenic

dynamic symptoms: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; and (d) Stigmatization/Self-Blame. Hierarchical regression analyses with unordered predictors and found the following results:

Hypothesis 6a: Perception of family support accounted for approximately .02% of the variation in traumatic sexualization symptoms over and above trauma severity and having received treatment. Sense of ethnic identity accounted for approximately .01% of the variation in traumatic sexualization symptomatology over and above trauma severity, having received treatment, and family support. Neither perception of family support nor ethnic identity was a significant predictor of traumatic sexualization symptoms. Thus, hypothesis 6a was not supported.

Hypothesis 6b: Perception of family support accounted for approximately 6% of the variation in betrayal symptoms over and above trauma severity and having received treatment. Sense of ethnic identity accounted for approximately 3% of the variation in betrayal symptomatology over and above trauma severity, having received treatment, and social support. Perception of family support was a significant predictor of betrayal symptoms. Ethnic identity was not significant predictors of betrayal symptoms. Thus, hypothesis 6b was partially supported.

Hypothesis 6c: Perception of family support accounted for approximately 3% of the variation in powerlessness symptoms over and above trauma severity and having received treatment. Sense of ethnic identity accounted for approximately .02% of the variation in powerlessness symptomatology over and above trauma severity, having received treatment, and family support. Neither perception of family support or ethnic identity was a significant predictor of powerlessness symptoms. Thus, hypothesis 6c was not supported.

Hypothesis 6d: Perception of family support accounted for approximately 4% of the variation in self-blame/stigmatization symptoms over and above trauma severity and having received

treatment. Sense of ethnic identity accounted for approximately .04% of the variation in self-blame/stigmatization symptomatology over and above trauma severity, having received treatment, and family support. Neither perception of family support or ethnic identity was a significant predictor of self-blame/stigmatization symptoms. Thus, hypothesis 6d was not supported.

The seventh hypothesis predicted that within the recruited sample, when controlling for trauma severity and having received therapy, a greater perception of family support and sense of ethnic identity would predict a lower endorsement of unhealthy attitudes towards romantic relationships. A hierarchical regression analysis found that a greater perception of family support predicted a lower endorsement of unhealthy attitudes towards dating over and above trauma severity and having received treatment, accounting for approximately 10% of the variation in attitudes. As well, a greater sense of ethnic identity predicted a lower endorsement of unhealthy attitudes over and above trauma severity, having received treatment, and familial support, accounting for approximately 4% of the variation in the presence of unhealthy attitudes towards dating. Both perception of family support and sense of ethnic identity were significant predictors of unhealthy attitudes towards romantic relationships. Thus, hypothesis 7 was supported.

CHAPTER V

Discussion

The present study utilized the theory of traumagenic dynamics to examine how symptomatology resulting from CSA is related to the attitudes adolescent females have towards interpersonal relationships. In examining this relationship, perception of familial support and sense of ethnic identity were examined as protective factors against the endorsement of unhealthy attitudes towards romantic relationships, and trauma severity and exposure to domestic violence were examined as risk factors for the endorsement of unhealthy attitudes towards romantic relationships. In this chapter, the findings of the present study will be examined and interpreted, the limitations of the study will be presented, clinical implications will be discussed, and directions for future research will be suggested.

Interpretation of Findings

The first question investigated by this study asked what the relationship was between traumagenic dynamics symptomatology and attitudes toward romantic relationships by adolescents who have experienced CSA. Guided by previous research and Finkelhor & Browne's (1985, 1986, 1988) theory of the relationship between the constructs of CSA-related symptomatology and interpersonal and attitudinal consequences, it was hypothesized that a positive relationship would exist between traumagenic dynamic symptoms as a whole and endorsement of unhealthy attitudes toward romantic relationships. It was also hypothesized that a positive relationship existed between each of the specific traumagenic dynamic symptoms: (a) Traumatic Sexualization; (b) Betrayal; (c) Powerlessness; (d) Stigmatization/Self-Blame, and the endorsement of unhealthy attitudes toward romantic relationships. In analyses examining these hypotheses, trauma severity and treatment were controlled for. The results of a bivariate

correlation found no relationship existed between traumagenic dynamic symptoms as a whole and the endorsement of unhealthy attitudes towards romantic relationships. Additionally, no relationship was found when bivariate correlations between each of the four specific traumagenic dynamic symptoms and attitudes toward relationship were conducted.

Traumagenic dynamic symptoms have been conceptualized as cognitive appraisals that can negatively impact one's basic assumptions about safety, meaningfulness, and self-worth, and thereby impact interpersonal functioning (Kendall-Tackett & Marshall, 1998; Ramirez, 2009). Therefore, it was striking that although this sample reported experiencing traumagenic dynamic symptoms and 69% of the sample reported being in a romantic relationship at the time of participation, this did not correlate with an endorsement of unhealthy attitudes towards romantic relationships. It is possible that the sample did not endorse a level of traumagenic dynamic symptomatology that was high enough to affect their attitudes towards romantic relationships. (Mean = 1.59, SD = 0.44 for overall symptoms; Traumatic Sexualization Mean = 1.43, SD = 0.91; Betrayal Mean = 1.94, SD = 0.58; Powerlessness Mean = 1.60, SD = 0.68; Self-blame/Stigmatization = 1.52; SD = 0.49.)

Additionally, the relationship that has been found by other studies between traumagenic dynamics and negative effects on interpersonal relationships (Cantón-Cortés, Cantón, & Cantón, 2013; Finkelhor & Browne, 1985; Senn, Carey, & Coury-Donziger, 2012) has generally been explored in adult relationships. It may be that this relationship between traumagenic dynamic symptomatology and an endorsement of unhealthy attitudes toward romantic relationships develops over time, and that adolescents' traumagenic dynamic symptomatology has not yet translated to how they perceive romantic relationships.

The second question investigated by this study asked whether past or present exposure to domestic violence serves as a risk factor for traumagenic dynamic symptomatology in adolescent females who have experienced CSA. It was hypothesized that a positive relationship existed between these variables so that within the sample, an exposure to domestic violence would be related an endorsement of overall traumagenic dynamic symptomatology. The impact of domestic violence was examined because it can result in similar behavioral, psychological, and emotional outcomes as CSA (Cohen, et al., 1996), and because adolescents who have been exposed to domestic violence are at higher risk for being involved in teen dating violence (Fantuzzo, et al., 1991). The results of a bivariate correlation found no relationship existed between these variables, concluding that exposure to domestic did not serve as a risk factor for traumagenic dynamic symptomatology in this sample. Although similar behavioral, psychological, and emotional outcomes are related to CSA and exposure to domestic violence, these outcomes may be related to the generalized symptoms that are seen in these populations such as anxiety, hostility, increased aggression, withdrawal, depression, and low self-esteem (Cohen, et al., 1996) and not to the traumagenic dynamic symptoms that have been conceptualized as specific to CSA.

The third question investigated by this study asked whether greater trauma severity served as a risk factor for experiencing greater traumagenic dynamic symptomatology in adolescent females who have experienced CSA. It was predicted that increased trauma severity would predict greater traumagenic dynamic symptomatology. The results of a simple regression analysis supported this hypothesis. This finding is consistent with the literature, which states that more severe CSA is related to greater psychological symptomatology (Fortier, et al., 2009, Kendall-Tackett, et al., 1993).

A follow-up analysis found that severity of sexual abuse also predicted the specific traumagenic dynamic symptoms of betrayal, powerlessness, and stigmatization/self-blame, but did not find support for trauma severity significantly predicting the traumagenic dynamic symptoms of traumatic sexualization. While the significant predictions of betrayal, powerlessness, and stigmatization/self-blame were expected, the non-significant result of the relationship between trauma severity and traumatic sexualization was unexpected. Initially, a significant relationship was expected between trauma severity and traumatic sexualization since Finkelhor and Browne (1985) noted that abuse that includes physical force results in this symptom. However, they also noted that this symptom is related to experiencing sex as confusing, fetishized, or a way to manipulate others. Based on the findings of this study, it appears that severity of abuse by itself does not lead to traumatic sexualization, but some of the other distressing experiences related to sex need to also be present to result in this symptom. The findings of these analyses suggest that thorough assessments of an adolescent's abuse experience should be completed when providing treatment for CSA so that one can better conceptualize the psychological symptomatology that may be presented. As well, when greater trauma severity is reported, the adolescent's experiences of betrayal, powerlessness, and stigmatization/self-blame should particularly be investigated and addressed.

The fourth question investigated by this study asked whether greater trauma severity served as a risk factor for a greater endorsement of unhealthy attitudes toward romantic relationships by adolescent females who have experienced CSA. It was predicted that increased trauma severity would predict a greater endorsement of unhealthy attitudes toward romantic relationships. The results of a simple regression analysis indicated that the severity of sexual abuse did not predict presence of unhealthy attitudes toward romantic relationships, and is

therefore not a risk factor for the development of these attitudes. This finding is consistent with previous analyses of this study that concluded severity of abuse was a risk factor for greater traumagenic dynamic symptomatology but that traumagenic dynamic symptomatology was unrelated to attitudes toward romantic relationships. Since neither the severity of CSA nor the symptomatology directly resulting from CSA are related towards unhealthy attitudes towards romantic relationships, it appears there is not an overall relationship between CSA and adolescents attitudes towards dating violence. This is a promising finding: the literature has reported that adults who have experienced CSA are likely to experience distress and dissatisfaction with intimate partner relationships (Briere, 1996; Courtois, 1979; DiLillo, 2001, DiLillo & Long, 1999; Jehu, 1988). If adolescents who have experienced CSA are not yet experiencing this interpersonal distress, they may benefit from interventions that support the positive interpersonal experiences they have and prevent them from entering into the more distressing intimate relationships that adult CSA survivors have been reported to experience.

The fifth question investigated in this study asked what the relationship was between the perception of family support and sense of ethnic identity in adolescent females who have experienced CSA. It was predicted that a positive relationship would exist between these variables. The results of a bivariate correlation indicated there was not a relationship between perception of family support and sense of ethnic identity. This was an exploratory hypothesis based on research findings that both variables can serve as protective factors against traumatic experiences to facilitate positive and healthy development and adjustment (Elliott & Carnes, 2001; LaFromboise, et al., 1993; Lee, 2005; Merrill, et al., 2001; Operario & Fiske, 2001; Phinney, 1990, 1992; Phinney, et al., 1997; Phinney & Ong, 2007; Tremblay, et al., 1999), and that perceived support is related to ethnic identity (Gaylord-Harden, et al. 2007). The lack of a

relationship between these variables in the present study, along with the greater mean score on the measure of ethnic identity ($M= 3.31$, $SD= 0.78$) than perceived social support ($M= 2.41$, $SD= 0.88$), indicates that this sample may have experienced a greater connection to their ethnic group than to their families. This could be a function of the proportion of participants who were living in a single-parent home (71%) or in a home in which neither parent was present (19%). As a result of these family constellations in which they were not living with one or both of their parents, it is possible that participants of this study did not perceive support from their families and looked for this support elsewhere in their communities. Clinicians working with this population should be aware of this dynamic in clients' family functioning so that interventions can be designed to take into account non-traditional figures whom abused children can identify in their lives to serve as sources of support.

The sixth and seventh questions investigated in this study asked if whether the presence of increasing trauma severity and having had treatment, perceived family support and a sense of ethnic identity served as protective factors against the presence of traumagenic dynamic symptomatology and the endorsement of unhealthy attitudes towards romantic relationships. These analyses concluded that a higher perception of family support was related to lower traumagenic dynamic symptoms and lower endorsement of unhealthy attitudes towards dating, and therefore served as a protective factor for both of these variables. Since there was no relationship between sense of ethnic identity and traumagenic dynamic symptoms, ethnic identity was not found to serve as a protective factor against experiencing traumagenic dynamic symptoms in this sample. However, sense of ethnic identity was found to be a protective factor against endorsing unhealthy attitudes towards romantic relationships.

Results of these analyses parallel previous findings that a perception of family support is related to lower psychological symptomatology related to CSA (Elliott & Carnes, 2001; Leifer, et al., 2001; Merrill, et al. 2001; Richard & Branch, 2012; Tremblay, H'ebert, & Pich', 1999; Vranceanu, et al., 2007), and thereby provides further evidence about the integral nature of familial support in promoting the psychological well-being of adolescents who have experienced CSA. Follow-up analyses found that perception of greater family support was also related to lower symptomatology of the traumagenic dynamic symptom of betrayal. This relationship makes intuitive sense because an adolescent who feels supported by those whom she looks to care for her is less likely to feel betrayed by these individuals. The non-significant relationship between perception of family support and the traumagenic dynamic symptom of traumatic sexualization was expected given that traumatic sexualization describes the victim's experience with the perpetrator (Finkelhor & Browne, 1985). Even with familial support, it is likely that an adolescent who had traumatic sexual experiences continues to view sex as a traumatic experience. The non-significant relationship between perception of family support and the traumagenic dynamic symptoms of powerlessness and stigmatization/self-blame were not expected, however.

Based on Finkelhor & Browne's (1985, 1988) explanation that powerlessness increases when a child feels that she is unable to make adults understand what she is experiencing and that stigmatization/self-blame is related to how a child views others as perceiving her for having experienced CSA, a lower perception of family support would be related to a greater sense of both these dynamics. It stands to reason then that an increased perception of family support would work to shield against the feelings of powerlessness and stigmatization/self-blame. However, results of this study found that while a lower perception of family support may serve

as a risk factor in exacerbating the symptoms of powerlessness and stigmatization/self-blame symptomatology, the inverse is not true: a higher perception of support does not buffer against these symptoms.

Both perception of familial support and sense of ethnic identity served as protective factors to the endorsement of unhealthy attitudes toward romantic relationships. This finding is noteworthy in conjunction with the prior analysis that found no relationship between perception of familial support and sense of ethnic identity. It appears that although there is not a relationship between the two factors, both familial support and ethnic identity serve to buffer against the acceptance of dating violence. It is likely that adolescents receive and internalize messages regarding positive relationships from both family and community members; therefore, adults in both areas can serve as positive influences for adolescents as they begin to explore dating and romantic relationships. This finding is especially important for those adolescents who do not have strong familial support because it indicates that helping them establish a strong sense of ethnic identity may provide some similar benefits as familial support.

Overall, this study concluded that the severity of CSA predicted traumagenic dynamic symptomatology but that this symptomatology was not correlated with an unhealthy endorsement of unhealthy romantic relationships. Additionally, severity of trauma was not directly related to increased endorsement of unhealthy romantic relationships. Perception of familial support was determined to be a protective factor against experiencing more severe traumagenic dynamic symptomatology and perception of familial support as well as sense of ethnic identity were determined to be protective factors against endorsing unhealthy attitudes towards romantic relationships.

Limitations

There are a number of limitations in the present study. First, the study is using a sample of convenience. The participants in this study were adolescent girls who are referred to a Regional Diagnostic and Treatment Center (RDTC) for assessment of sexual abuse in an urban hospital in the Northeast United States. These are girls whose CSA has been disclosed and whose guardians have followed up with the Division of Child Protection and Permanency (DCP&P) referral to bring them to the RDTC. Therefore, only a small portion of the population of interest (adolescent female survivors of CSA) was assessed in this research. The effects of CSA for girls whose CSA has not been disclosed or whose parents do not follow DCP&P's directive to come to the RDTC are unable to be considered in the present study. The sample for this study was also recruited from just one outpatient clinic, with some of the participants having already received treatment for CSA. This serves as a limitation because although having had treatment was controlled for in the analyses for which it was relevant, it is likely that intra-clinic and inter-clinic differences in therapy would have differential effects on symptomatology and attitudes towards relationships following CSA. Since participants and their guardians were able to decide whether to participate in this study, the participants were self-selected. Due to this, it is not possible to determine whether these participants are representative of all adolescent female CSA survivors.

In addition to limitations due to recruitment, there are measurement-related limitations. The study employs mainly self-report measures. Self-reports are subject to participants' inaccurate memory and to response bias in which socially acceptable responses are given (Kail, 2010). There are also limitations based on specific measures that were chosen for this study. As discussed in Chapter III, the measure assessing for trauma severity, The Sexual Abuse Severity Score (Zink, Klesges, Stevens, & Decker, 2009), was selected for its empirical validity and

because its chart review checklist format minimized the potential distress adolescents may have experienced if asked to recount details of their abuse in a non-therapeutic interaction. However, this measure has a limitation in that it does not assess some severity-related variables that have been noted in the literature to be related to increased psychological symptomatology, most notably participants' relationship to the perpetrator (Chaffin, et al., 1997; Feiring et al., 2002; Kallstrom-Fuqua, et al., 2004; Kendall-Tackett et al., 1993; Wolfe Gentile & Wolfe, 1989). For instance, a familial relationship with the perpetrator has been associated with worse psychological outcomes (Putnam, 2003; Trickett, Noll, Reiffman, & Putnam, 2001; Ullman, 2007) such as PTSD symptomatology and self-blame. Since the victim-perpetrator relationship was not assessed through the SASS, the results of the present study's exploration of trauma severity's predictive value of traumagenic dynamic symptomatology may not provide a full picture of the relationship. In addition to its direct impact on symptomatology, the relationship a victim has to her perpetrator may also explain the relevance of ethnic identity as a protective factor of symptomatology and attitudes about romantic relationships. If a perpetrator is someone who shares an ethnic background with the girl, this may negatively impact her own sense of ethnic identity, which in turn may affect whether ethnic identity can serve as a protective factor against increased symptomatology or unhealthy attitudes towards romantic relationships. Further, if the perpetrator is someone with whom the girl had a close relationship or whom she observed in a romantic relationship with someone she is close to, the abuse may negatively impact her attitudes towards relationships. Unfortunately, the lack of data regarding the relationship participants' had to their perpetrators diminishes our ability to more thoroughly understand the relationship between trauma severity and the outcome variables of this study.

Finally, as discussed in Chapter III, adolescent conceptualizations of romantic relationships do not fit an adult-like pattern and can differ drastically from that of adults (Wekerle & Wolfe, 1998). This study had a mean age of 15.01 years and, as stated in Chapter IV, the measure assessing their attitudes towards relationships (IPVAS) had been empirically validated with a university population. This measure was selected for the present study because other adolescent dating measures assessed dating behaviors as opposed to attitudes (e.g., Conflict in Adolescent Dating Relationships; Wolfe, et al., 2001), or if assessing attitudes, they were specific to heterosexual relationships (e.g., The Attitudes towards Dating Violence Scales; Price et al., 1999). While the IPVAS allowed for measurement of attitudes towards both same-sex and heterosexual relationships, since it was validated with a young adult population, the conceptualization for relationships that is utilized by adolescents may not have been considered adequately. Consequently, the adolescents' attitudes towards relationships may have not been captured effectively by the measure utilized in this study.

Clinical Implications

Neither traumagenic dynamic symptomatology nor the severity of CSA was related towards participants endorsing an unhealthy attitude towards romantic relationships. This contrasts with the relationship between traumagenic dynamics and negative effects on interpersonal relationships that has been found in studies with adult survivors of CSA (Cantón-Cortés, Cantón, & Cantón, 2013; Finkelhor & Browne, 1985; Senn, Carey, & Coury-Donziger, 2012). If this finding is indeed due to adolescents not having yet developed the attitudes that can lead to the unhealthy relationships that have been found to exist for adult survivors of CSA (Bank & Burrason, 2001; Coid, 2001; Wolfe et al., 2004), this provides an excellent point of intervention for clinicians, teachers, and other adults working with adolescent CSA survivors to

provide services in the forms of therapy and/or psychoeducation that are aimed at prevention of the development unhealthy attitudes towards romantic relationships.

This study found that although participants reported a greater sense of ethnic identity than perception of family support, for those participants who perceived familial support, it served as a protective factor against negative symptomatology related to CSA. Based on this finding, clinicians should assess for family support when completing CSA assessments. Further, interventions should include augmenting familial support and integrating supportive family members into the adolescent's treatment. Additionally, both sense of ethnic identity and perception of familial support served as protective factors against the endorsement of unhealthy attitudes towards romantic relationships. Based on these findings and on literature that reports ethnic identity to be associated with the positive sense of belonging to one's group and positive self esteem (Phinney, et al., 1997), it may be useful to target adolescents' sense of ethnic identity as an avenue for them to receive the support they are not receiving from their family members. Clinicians and others who work with these adolescents should consider having discussions with them about their sense of ethnic identity. If they endorse feeling a strong ethnic identification, individuals from the adolescent's ethnic community who could serve as supports should be identified and provided with psychoeducation to be able to offer the adolescent the support she may not perceive from her family.

Recommendations for Future Research

The goal of the current research was to gain an understanding of the relationship between CSA-related symptomatology and adolescents' attitudes towards romantic relationships, as well as protective and risk factors of increased acceptance of unhealthy relationships. While this study highlights the significant relationships between the primary variables, numerous areas of inquiry remain.

First, as indicated in the limitations, since the measurement of attitudes towards romantic relationships was validated on a university population, it may not have adequately captured the adolescent conceptualization of romantic relationships. As discussed above, the measure was chosen because other adolescent dating measures assessed dating behaviors instead of attitudes or were specific to heterosexual relationships. The development of adolescent-specific dating attitude measures that are inclusive of same-sex and heterosexual relationships would be beneficial in expanding on the findings of the present study.

Also noted in the limitations, the present research was conducted in one outpatient clinic in Newark, NJ. It is recommended that future studies recruit from numerous clinics that vary geographically. Sampling from adolescents from different types of treatment centers (e.g., hospital, private, residential), and from adolescents who have not been exposed to treatment would add to our understanding of the environmental factors that may influence the development of traumagenic dynamic symptomatology and/or unhealthy attitudes towards dating. Additionally, to defend against self-selection bias, interviews with all adolescents who have been identified by DCP&P as having experienced CSA could be completed.

Since this study found that adolescents who have experienced severe CSA may not yet have developed unhealthy attitudes towards relationships even though they may experience symptomatology, the mediating effect of traumagenic dynamic symptomatology between trauma severity and attitudes towards relationships should be further investigated. Additionally, since perception of familial support was determined to be a protective factor against increased symptomatology, a longitudinal examination of interventions involving trusted family members such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT; Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004), Focused

Treatment Interventions (FTI; Ralston, 1982; 1996; 1998), Family Resolution Therapy (Saunders & Meinig 2000; 2001), Multisystemic Therapy (MST; Henggeler et al., 1999), as well as interventions that can augment familial support should be undertaken to examine whether this can help promote healthy attitudes towards romantic relationships and prevent adolescents from entering into distressing intimate relationships as adults. Further, since ethnic identity was found to be a protective factor against endorsing unhealthy attitudes toward romantic relationships, longitudinal examination regarding interventions that involve members of adolescents' ethnic communities in treatment should be undertaken to examine whether this involvement helps to promote healthy attitudes towards romantic relationships and prevent adolescents from entering into distressing intimate relationships as adults. Examinations of both these protective factors may benefit from matched comparison groups to determine whether ethnic group support is as beneficial as familial support. While this study found ethnic identity to be a protective factor against endorsing unhealthy attitudes toward romantic relationships, it is not known if this finding is generalizable to all ethnic groups. Due to the small sample ($n=81$), there was not enough power to examine group differences specific to ethnic group in regard to the outcome variables. Future research should examine this to determine how ethnic identity varies as a protective factor amongst various groups. As addressed above regarding limitations, to better understand the relevance ethnic identity has in regards to symptomatology and attitudes towards relationships, the ethnicity perpetrator need to be assessed to determine how this affects adolescents' sense of ethnic identity, and consequently the role ethnic identity can play in the adolescents' symptomatology and attitudes towards romantic relationships.

This study did not find a relationship between exposure to domestic violence and traumagenic dynamic symptomatology, it is unclear if this is because domestic violence is related

to the more generalized behavioral, psychological, and emotional outcomes of CSA as opposed to traumagenic dynamic symptomatology. To evaluate this possibility, assessments of the more generalized symptoms (such as anxiety, hostility, increased aggression, withdrawal, depression, and low self-esteem) and the specific symptoms of traumagenic dynamics should be completed in samples consisting of individuals who have experienced CSA only, those who have been exposed to domestic violence only, and those who have experienced both CSA and domestic violence. This would allow for a more nuanced understanding of how the interaction between domestic violence and CSA affects behavioral, psychological, and emotional functioning.

In conclusion, this research highlighted some of the relationship between CSA-related symptomatology, and protective and risk factors of this symptomatology. It is hoped that this study will encourage further research and the development of clinical interventions to gain a better understanding of adolescents dating attitudes and experiences in relation to their experiences of sexual abuse, so that interventions can be implemented that prevent these adolescent girls from experiencing abusive relationships as adults.

References

- Adams, G. R., Shea, J. A., & Fitch, S. A. (1979). Toward the development of an objective assessment of ego-identity status. *Journal of Youth and Adolescence*, 8, 223-237.
- Aguilar-Cafaie, M. E., Roshani, M., Hassanabadi, H., & Afruz, Z. M. (2011). Risk and protective factors for residential foster care adolescents. *Children and Youth Services Review*, 33, 1-15.
- Ainsworth, M. S. (1978). The development of infant-mother attachment. In B. M. Caldwell, & H. N. Ricciuti (Eds.), *Review of child development and research* (Vol. 3, pp. 1-94). Chicago, IL: University of Chicago.
- American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)Arlington, VA: American Psychiatric Publishing.
- American Psychological Association (1996). *APA presidential task force on violence and the family report*. Washington DC: Author.
- Anda, E. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Giles, W. H. (2006). The enduring effects of abuse and related adverse: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256, 174-186.
- Andrews, G., Corry, J., Slade, T., Issakidis, C., & Swanston, H. (2004). Child Sexual Abuse. In M. Ezzati, A. D. Lopez, A. Rodgers & C.J.L. Murray (Eds.), *Comparative Qualification*

- of Health Risks*: (Vol. 2, pp. 1851-1940). Geneva, Switzerland: World Health Organization.
- Appel, A. E., & Holden, G. W. (1998). Co-occurring spouse and child abuse: Implications for CPS practice. *APSAC Advisor*, 11(1), 11-14.
- Baartman, H.E.M. (1998). Compassion and scepticism in child sexual abuse: Historical aspects and explanations. *International Review of Victimology*, 5, 189-202.
- Bagley, C., & Young, L. (1989). Depression, self-esteem, and suicidal behavior as sequels of sexual abuse in childhood: Research and therapy. In M. Rothery & G. Cameron (Eds.), *Child maltreatment: Expanding our concept of healing* (pp. 183-209). Hillsdale, NJ: Erlbaum.
- Balgopal, P. (1988). Social networks and Asian Indian families. In C. Jacobs & D. Bowles (Eds.), *Ethnicity and race: Critical concepts in social work* (pp. 18-33). Silver Spring, MD: National Association of Social Workers.
- Bandura, W. (1973). *Aggression: A social learning analysis*. Englewood Cliffs, NJ: Prentice-Hall.
- Bank, L., & Burrason, B. (2001). Abusive home environments as predictors of poor adjustment during adolescence and early adulthood. *Journal of Community Psychology*, 29, 195-217.
- Beauvis, F., & Oetting, E. (1999). Drug use, resilience, and the myth of the golden child. In M. Glantz & J. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 101-107). New York, NY: Plenum Press.
- Behl, L.E., Crouch, J.L., May, P.F., Valente, A.L., & Conyngham, H.A. Ethnicity in child maltreatment research: A content analysis. *Child Maltreatment*, 6(2), 143-147.

Beitchman, J. H., Zucker, K. J., Hood, J. E., daCosta, G. A., Akman, D., & Cassavia, E. (1992).

A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect*, 16, 101-118.

Bender, L., & Blau, A. (1937). The reactions to sexual relations with adults. *American Journal of Orthopsychiatry*, 7, 500-518.

Bensley, L. S., van Eenwyk, J., & Simmons, K. W. (2000). Self-reported childhood sexual and physical abuse and adult HIV-risk behaviors and heavy drinking. *American Journal of Preventive Medicine*, 18, 151-158.

Berliner, L., & Wheeler, J. (1987). Treating the effects of sexual abuse on children. *Journal of Interpersonal Violence*, 2, 415-434.

Birman, D., & Trickett, E. (2001). The process of acculturation in first generation immigrants: A study of Soviet Jewish refugee adolescents and parents. *Journal of Cross-Cultural Psychology*, 32(4), 456-477.

Birman, D., Trickett, E., & Vinokurov, A. (2002). Acculturation and adaptation of Jewish refugee adolescents: Predictors of adjustment across life domains. *American Journal of Community Psychology*, 30(5), 585-607.

Blume, S. (1990). *Secret survivors: Uncovering incest and its after effects in women*. New York: Wiley.

Bolen, R.M., & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review*, 73(3), 281-313.

Bookwala, J., Frieze, I. H., Smith, C., & Ryan, K. (1992). Predictors of dating violence: A multivariate analysis. *Violence and Victims*, 7, 297-311.

- Borsato, G. N. (2008). *Perceived discrimination, racial/ethnic identity, and adjustment among Asian American and Latino early adolescents*. Available from ProQuest Dissertations and Theses database. (UMI No. 3313536).
- Bowlby, J. (1982). *Attachment and loss: Vol. 1: Attachment* (2nd ed.). New York, NY: Basic Books.
- Briere, J. (1995). *Professional manual for the Trauma Symptom Checklist for Children (TSCC)*. Odessa, FL: Psychological Assessment Resources.
- Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported. *Child Abuse & Neglect*, 27, 1205-1222.
- Briere, J. N., & Elliott, D. M. (1994). Immediate and longterm impacts of child
- Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse & Neglect*, 14, 357-364.
- Briere, J., 1996. *Therapy for adults molested as children* (2nd ed.), Springer Publishing, New York.
- Brodeur, M.D. (2009). *Assessment of resilience and its protective factors in outreach workers*. Available from ProQuest Dissertations and Theses database. (UMI No. 3385340)
- Brown, J., Cohen, P., Johnson, J. G., & Smailes, E. M. (2000). Childhood abuse and neglect: Specificity of effects on adolescent and young adult depression and suicidality. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 1490-1496.
- Browne, A., & Finkelhor, D. (1986). The impact of child sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66-77.
- Bruce, E., & Waelde, L. C. (2008). Relationships of ethnic identity and trauma symptoms to delinquency. *Journal of Loss and Trauma*, 13, 395-405.

- Burgess, A. W. (1988). *Children traumatized in sex rings*. Washington, DC: National Center for Missing and Exploited Children.
- Cantón-Cortés, D., Cortés, M., & Cantón, J. (2012). The role of traumagenic dynamics on the psychological adjustment of survivors of child sexual abuse. *European Journal Of Developmental Psychology*, 9(6), 665-680. doi:10.1080/17405629.2012.660789
- Casey, E.A., & Nurius, P.S. (2005). Trauma exposure and sexual revictimization risk: Comparisons across single, multiple incident, and multiple perpetrator victimizations. *Violence Against Women*, 11(4), 505–530.
- Centers for Disease Control and Prevention (2010). Understanding teen dating violence. Retrieved April 8, 2011, from http://www.cdc.gov/violenceprevention/pdf/TeenDatingViolence_2010-a.pdf
- Centers For Disease Control And Prevention (2011, February 7). Preventing teen dating violence. Retrieved April 8, 2011, from <http://www.cdc.gov/Features/DatingViolence/>
- Chaffin, M., Wherry, J. N., Newlin, C., Crutchfield, A., & Dykman, R. (1997). The abuse dimensions inventory: Initial data on a research measure of abuse severity. *Journal of Interpersonal Violence*, 12, 569–589.
- Check, J. V., & Malamuth, N. (1985). An empirical assessment of some feminist hypotheses about rape. *International Journal of Women's Studies*, 8, 414-423.
- Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). *How to Implement Trauma-Focused Cognitive Behavioral Therapy*. Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.
- Cobb, S. (1976). Social support as a mediator of life stress. *Psychosomatic Medicine*, 38, 300–314.

- Coffey, P., Lettenberg, H., Hening, K., Turner, T., & Bennett, R. T. (1996). Mediators of the long-term impact of child sexual abuse: Perceived stigma, betrayal, powerlessness, and self-blame. *Child Abuse & Neglect*, 20(5), 443-455.
- A. (1988). *Statistical power analysis for the behavioral sciences*. (2nd edition). Hillsdale NJ: Erlbaum.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2000). Trauma-focused cognitive behavioral therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence*, 15(11), 1202-1223.
- Cohen, J.A., Deblinger, E., Mannarino, A.P., & de Arellano, M.A. (2001). The importance of culture in treating abused and neglected children: an empirical review. *Child Maltreatment*, 6 (2), 148-157.
- Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98, 310–357.
- Coid, J., Petruckevitch, A., Feder, G., Chung, W., Richardson, J., & Moorey, S. (2001). Relation between childhood sexual and physical abuse and risk of revictimisation in women: A cross-sectional survey. *The Lancet*, 358, 450–454.
- Cokely, K. (2005). Racial(ized) identity, ethnic identity, and Afrocentric values: Conceptual and methodological challenges in understanding African American identity. *Journal of Counseling Psychology*, 52, 517–526.
- Collings, S. J., & Payne, M. F. (1991). Attributions of causal and moral responsibility to victims of father-daughter incest: An exploratory examination of five factors. *Child Abuse and Neglect*, 15, 513-521.

- Connolly, J., Furman, W., & Konarski, R. (2000). The role of peers in the emergence of heterosexual romantic relationships in adolescence. *Child Development, 71*(5), 1395-1408.
- Compas, B.E., Hinden, B.R., & Gerhardt, C.A. (1995). Adolescent development: Pathways and processes of risk and resilience. *Annual Review of Psychology, 46*, 265-293.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., Van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390-398.
- Cornell, S., & Hartmann, D. (2007). *Ethnicity and race: Making identities in a changing world*. Thousand Oaks, CA: Pine Forge Press.
- Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: A self-reports measure of protective factors against child-maltreatment. *Child Abuse & Neglect, 34*, 762-772.
- Courtois, C. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma, Theory, and Research, 8*(1), 86-100.
- Courtois, C.A., (1979). The incest experience and its aftermath. *Victimology: an International Journal 4*, pp. 337-347.
- Crittenden, P., & Ainsworth, D. S. (1989). Attachment and child abuse. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 432-463). New York, NY: Cambridge University Press.
- Cyr, M., McDuff, P., & Wright, J. (2006). Prevalence and predictors of dating violence among adolescent female victims of child sexual abuse. *Journal of Interpersonal Violence, 21*(8), 1000-1017.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. A. (2012).

Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal Of Orthopsychiatry*, 82(2), 187-200.
doi:10.1111/j.1939-0025.2012.01154.x

DeBellis, M. D. (2001). Developmental traumatology: the psychobiological development of maltreated children and its implications for research, treatment, and policy. *Development and Psychopathology*, 13, 539-564.

DeBellis, M. D., & Putnam, F. (1994). The psychobiology of childhood maltreatment. *Child and Adolescent Psychiatry Clinics of North America*, 3, 663-678.

Deblinger, E., Stauffer, L., & Landsberg, C. (1994). The impact of a history of child sexual abuse on maternal response to allegations of sexual abuse concerning her child. *Journal of Child Sexual Abuse*, 3, 67-75.

DiLillo, D. (2001). Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues. *Clinical Psychology Review*, 21(4), 553-576.

DiLillo, D. and Long, P.J. (1999). Perceptions of couple functioning among female survivors of child sexual abuse. *Journal of Child Sexual Abuse* 7, 59-76.

Dixon, Rayle, A., & Myers, J. E. (2004). Wellness in adolescence: The roles of ethnic identity, acculturation, and mattering. *Professional School Counseling*, 8, 81-90.

Dolan, Y. (1991). *Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors*. New York: Norton.

Dominquez, R. Z., Nelke, C.F. & Perry, B.D. (2001). Child Sexual Abuse. *Encyclopedia of Crime and Punishment*, 1, 202-207.

- Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003). The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect and household dysfunction during childhood. *Child Abuse & Neglect*, 27, 625–639.
- Dubow, E.F. & Ullman, D.G. (1989). Assessing social support in elementary school children: The survey of children's social support. *Journal of Clinical Child Psychology*, 18(1), 52-64.
- Edgards, K., & Ormstad, K. (2000). Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls. *Acta Paediatrica*, 88, 310–319.
- Edleson, J.L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, 5(2), 134-154.
- Edwards, C. (1997). *A test of theory: four traumagenic dynamics of sexual abuse in a population of adult female sexual abuse survivors*. Available from ProQuest Dissertations and Theses database. (UMI No. 9819723)
- Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to sexual abuse of their children: A review of the literature. *Child Maltreatment*, 6(4), 314-331.
- Elliott, D. M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and symptomology. *Behavioral Sciences and the Law* 12, 261-277.
- Erickson, E. (1968). *Identity: Youth and crisis*. New York: Norton.
- Ernst C., Angst J., Foldenyi, M. (1993), The Zurich study, XVII: sexual abuse in childhood. Frequency and relevance for adult morbidity: data of a longitudinal epidemiological study. *European Archives of Psychiatry and Clinical Neuroscience*, 242, 293–300.
- Esparza, D. (1993). Maternal support and stress response in sexually abused girls ages 6–12. *Issues in Mental Health Nursing*, 14, 85-107.

- Eth, S., & Pynoos, R. S. (1985). *Post-traumatic stress disorder in children*. Los Angeles, CA: American Psychiatric Association.
- Fantuzzo, J.W., DePaula, L.M., Lambert, L., Martino, R., Ander, G., & Sutton, S. (1991). Effects of interpersonal violence on the psychological adjustment and competencies of young children. *Journal of Consulting and Clinical Psychology*, 59(2), 258-265.
- Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 39, 175-191.
- Feiring, C., Deblinger, E., Hoch-Espada, A., & Haworth, T. (2002). Romantic relationship aggression and attitudes in high school students: the role of gender, grade, and attachment and emotional styles. *Journal of Youth and Adolescence*, 31(5), 373-385.
- Feiring, C., Simon, V. A., & Cleland, C. M. (2009). Childhood sexual abuse, stigmatization, internalizing symptoms, and the development of sexual difficulties and dating aggression. *Journal of Consulting and Clinical Psychology*, 77, 127-137.
- Feiring, C., Taska, L., & Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: the role of shame in defining stigmatization. *Child Abuse & Neglect*, 20(8), 767-782.
- Feiring, C., Taska, K. S., & Lewis, M. (1998). Social support and children's and adolescents' adaptation to sexual abuse. *Journal of Interpersonal Violence*, 13, 240-260.
- Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: the role of shame and attributional style. *Developmental Psychology*, 38(1), 79-92.

- Ferguson D, Horwood L, Lynskey M (1996). Childhood sexual abuse and psychiatric disorder in young adulthood, II: psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1365–1374.
- Figley, C. R. (1998). Burnout as systemic traumatic stress: A model for helping traumatized family members. In C.R. Figley (Ed.), *Burnout in Families, The Systemic Costs of Caring* (pp. 15-28). Boca Raton, FL: CRC Press LLC.
- Figley, C. R. (2010a, March). The stress injuries paradigm: Advantages of an evidence-based spectrum of care and resilience. [PowerPoint slides]. Presented at *New Jersey Psychological Association Spring Conference, Iselin NJ*.
- Figley, C. R. (2010b). *PTSD: Its appearances and consequences* [PowerPoint slides]. Presented at *New Jersey Psychological Association Spring Conference, Iselin NJ*.
- Figley, C. R. & Nash, W. P. (Eds.) (2007). *Combat Stress Injury Theory, Research, and Management*. New York: Routledge.
- Fincham, F. D., Cui, M., Braithwaite, S., & Pasley, K. (2008). Attitudes toward intimate partner violence in dating relationships. *Psychological Assessment*, 20(3), 260-269.
- Finkelhor, D. (1979). *Sexually Victimized Children*. New York, NY: Free Press.
- Finkelhor, D. (1987). The sexual abuse of children: Current research reviewed. *Psychiatric Annals*, 17, 233–241.
- Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: an update. *Professional Psychology*, 21(5), 325-330.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55, 530-541.

- Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse*. Beverly Hills, CA: SAGE Publications.
- Finkelhor, D., & Browne, A. (1988). Assessing the long-term impact of child sexual abuse: A review and conceptualization. In L.E.A. Walker (Ed.), *Handbook on Sexual Abuse of Children* (3rd ed., pp. 55-69). New York, NY: Springer Publishing.
- Finkelhor, D., & Kendall-Tackett, K. (1997). A developmental perspective on the childhood impact of crime, abuse and violent victimization. In Mt. Hope Family Center, University of Rochester (Ed.), *Developmental perspectives on trauma: theory, research and intervention* (Vol. 8, pp. 1-31). Rochester, NY: University of Rochester Press.
- Finkelhor, D., & Dziuba-Leatherman, J. (1994). Children as victims of violence: A national survey. *Pediatrics*, 94, 413-420.
- Fontes, L.A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of Child Sexual Abuse*, 19, 491-518.
- Ford, J. D., & Courtois, C. A. (2009). Defining and understanding complex trauma and complex traumatic stress disorder. In C.A. Courtois & J.D. Ford (Eds.), *Treating Complex Traumatic Stress Disorders* (pp. 13-27). New York, NY: Guilford.
- Ford, J.D., Grasso, D., Greene, C., Levine, J., Spinazzola, J., van der Kolk, B. (2013). Clinical significance of a proposed development trauma disorder diagnosis: Results of an international survey of clinicians. *Journal of Clinical Psychiatry*, 74, 841-849. doi: 10.4088/JCP.12m08030

- Ford, J. D., Hartman, J. K., Hawke, J., & Chapman, J. (2008). Traumatic victimization, posttraumatic stress disorder, suicidal ideation, and substance abuse risk among juvenile justice-involved youths. *Journal of child and Adolescent Trauma*, 1, 75-92.
- Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revictimization: the mediating role of coping and trauma symptoms. *Psychology of Women Quarterly*, 33(3), 308-320.
- Freud, S. (1962). The aetiology of hysteria. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 191-221). London: Hogarth Press. (Original work published 1896).
- Friedrich, W. N., Leucke, W. J., Belike, R. L., & Place, V. (1992). Psychotherapy outcome of sexually abused boys. *Journal of Interpersonal Violence*, 7, 396-409.
- Friedrich, W.N., Urquiza, A.J. and Beilke, R.L. (1986). Behavior problems in sexually abused young children. *Journal of Pediatric Psychology* 11, 47-57.
- Garnezy, N. (1991). Resiliency and vulnerability to adverse developmental outcomes associated with poverty. *American Journal of Behavioral Science*, 34, 416-430.
- Gaylord-Harden, N. K., Ragsdale, B. L., Mandara, J., Richards, M. H., & Petersen, A. C. (2007). Perceived support and internalizing symptoms in African American adolescents: Self-esteem and ethnic identity as mediators. *Journal of Youth and Adolescence*, 36, 77-88.
- Goldman, J. D. G., & Padayachi, U. K. (2000). Some methodological problems in estimating incidence and prevalence in child sexual abuse research. *The Journal of Sex Research*, 37(4), 305-314.
- Goodwin, J. (1984). Incest victims exhibit post-traumatic stress symptoms. *Clinical Psychiatry News*, 12, 13.

- Green, B., Wilson, J., & Lindy, J. (1985). Conceptualizing post-traumatic stress disorder A psychosocial framework. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 53-69). New York: Brunner/Mazel.
- Hackett, G., Betz, N. E., Casas, J. M., & Rocha-Singh, I. A. (1992). Gender, ethnicity, and social cognitive factors predicting the academic achievement of students in engineering. *Journal of Counseling Psychology, 4*, 527-538.
- Harter, S. (1985). *Manual for the Social Support Scale for Children*. Denver, CO: University of Denver.
- Harter, S., Alexander, P.C. and Neimeyer, R.A. (1988). Long-term effects of incestuous child abuse in college women: social adjustment, social cognition, and family characteristics. *Journal of Consulting and Clinical Psychology 56*, 5–8.
- Haugaard, J. J., & Reppucci, N. D. (1988). *The sexual abuse of children: A comprehensive guide to current knowledge and intervention strategies*. San Francisco, CA: Jossey-Bass Publishers.
- Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *American Psychologist, 55*, 1036–1039.
- Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52*(3), 511-524.
- Hazzard, A. (1993). Trauma-related beliefs as mediators of sexual abuse impact in adult women survivors: A pilot study. *Journal of Child Sexual Abuse, 2* (3) 55-69.
- Hazzard, A., Celano, M., Gould, J., Lawry, S., & Webb, C. (1995). Predicting symptomology and self-blame among child sexual abuse victims. *Child Abuse & Neglect, 19*, 707–714.

- Helfer, T., & Kempe, C. (Eds.). (1974). *The Battered Child*. Chicago, IL: University of Chicago Press.
- Helms, J. (1990). *Black and White Racial Identity: Theory, Research, and Practice*. Westport, CT: Greenwood Press.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford Press.
- Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5, 377-391.
- Himelein, M. J., & McElrath, J. V. (1996). Resilience child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse & Neglect*, 20(8), 747-758.
- Holleran, L. K., & Waller, M. A. (2003). Sources of resilience among Chicano/a youth: Forging identities in the borderlands. *Child and Adolescent Social Work Journal*, 20(5), 335-350.
- Horowitz, M. (1976). *Stress response syndromes*. (2nd ed.). New Jersey: Jason Aronson.
- House, J. S. (1981). *Work stress and social support*. Reading, MA: Addison-Wesley.
- Hughes, H. M., Parkinson, D., & Vargo, M. (1989). Witnessing spouse abuse and experiencing physical abuse: A "double whammy"? *Journal of Family Violence*, 4(2), 197-209.
- Hulme, P. A. (2004). Retrospective measurement of childhood sexual abuse: A review of instruments. *Child Maltreatment*, 9, 201-217.
- Jackson, J.L., Calhoun, K.S., Amick, A.A., Maddever, H.M. and Habif, V.L. (1990). Young adult women who report childhood intrafamilial sexual abuse: subsequent adjustment. *Archives of Sexual Behavior* 19, 211-221.

- Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In C. R Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 15—34). New York: Brunner/Mazel.
- Jehu, D. (1988). *Beyond sexual abuse: Therapy with women who were childhood victims*. John Wiley and Sons, New York.
- Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: Attachment roles and social support. In P.B. Baltes & O. Brim (Eds.), *Life Span Development and Behavior* (pp. 253-286). New York, NY: Academic Press.
- Kail, R. V. (2010). *Children and their development* (5 ed.). Upper Saddle River, NJ: Pearson.
- Kaiser, L. M. (2000). *Ethnicity, religious coping and post-disaster support as predictors of posttraumatic stress disorder in children and adolescents*. (Doctoral dissertation). Retrieved from <http://scholar.lib.vt.edu/theses/available/etd-02282001-154512/unrestricted/kaiserthesis.pdf>
- Kallstrom-Fuqua, A. C., Weston, R., & Marshall, L. L. (2004). Childhood and adolescent sexual abuse of community women: Mediated effects on psychological distress and social relationships. *Journal of Consulting and Clinical Psychology*, 72, 980–992
- Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113, 164-180.
- Kendall-Tackett, K.A., & Marshall, R. (1998). Sexual victimization of children: Incest and child sexual abuse. In R.K. Bergen (Ed.) *Issues in intimate violence* (pp. 47-63). Newbury Park, CA: Sage.

- Kenny, M. E., & Stryker, S. (1996). Social network characteristics and college adjustment among racially and ethnically diverse first-year students. *Journal of College Student Development, 37*(6), 649-658.
- Kirschner, S., Kirschner, D., & Rappaport, R. (1993). *Working with adult incest survivors: The healing journey*. New York: Brunner/Mazel.
- Kiser, L. J., Heston, J., Milsap, P. A., & Pruitt, D. C. (1991). Physical and sexual abuse in childhood: Relationship with post-traumatic stress disorder. *American Academy of Child & Adolescent Psychiatry, 30*(5), 776-783.
- Krause, N. (1986). Social support, stress, and well-being. *Journal of Gerontology, 41*(4), 512-519.
- Labbe (2005). Ambroise Tardieu: The man and his work on child maltreatment a century before Kempe. *Child Abuse & Neglect, 29*(4), 311-324.
- Lacelle, C., Hébert, M., Lavoie, F., Vitaro, F., & Tremblay, R.E. (2012). Child sexual abuse and women's sexual health: The contribution of CSA severity and exposure to multiple forms of childhood victimization. *Journal of Child Sexual Abuse, 21*, 571-592.
- LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin, 114*, 395-412.
- Langford, C. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social Support: A conceptual analysis. *Journal of Advanced Nursing, 25*(1), 95-100.
- LeClair, L. (1993). *A study on the long-term effects of child sexual abuse: An empirical investigation of the post-traumatic stress disorder and traumagenic dynamic models*. Available from ProQuest Dissertations and Theses database. (UMI No. NQ52427)

- Lee, R.M. (2005). Resilience against discrimination: Ethnic identity and other-group orientation as protective factors for Korean Americans. *Journal of Counseling Psychology*, 5 (1), 36-44.
- Leifer, M., Kilbane, T., & Grossman, G. (2001). A Three-Generational Study Comparing A three-generational study comparing mothers of sexually abused children. *Child Maltreatment*, 6(4), 354-364.
- Lemieux, S. R., & Byers, S. E. (2008). The sexual well-being of women who have experienced child sexual abuse. *Psychology of Women Quarterly*, 32, 126–144.
- Lewis, S. F., & Fremouw, W. (2001). Dating violence: A critical review of the literature. *Clinical Psychology*, 21, 105-127.
- Liang, B., & Bogat, A. (1994). Culture, control, and coping: New perspectives on social support. *American Journal of Community Psychology*, 22(1), 123-147.
- Lipovsky, J., Swenson, C.C., Ralston, M.E., & Saunders, B.E. (1998). The abuse clarification process in the treatment of intrafamilial child abuse. *Child Abuse & Neglect*, 22(7), 729-741.
- MacMillan, H. L. (1998). Child abuse: A community problem. *Canadian Medical Association Journal*, 158, 1301–1302.
- Marmar, C, & Horowitz, M. (1988). Diagnosis and phase-oriented treatment of posttraumatic stress disorder. In J. Wilson, Z. Harel & B. Kahana (Eds.), *Human adaptation to extreme stress from the Holocaust to Vietnam* (pp. 81-102). New York: Plenum Press.
- McCubbin, L. D. (2003). *Resilience among native Hawaiian adolescents: ethnic identity, psychological distress and well-being*. Available from ProQuest Dissertations and Theses database. (UMI No. 3101340)

- McCullough, M. L. (2001). Freud's seduction theory and its rehabilitation: A Saga of One Mistake After Another. *Review of General Psychology*, 5(1), 3-22.
- McDonell, J., Ott, J., & Mitchell, M. (2010). Predicting dating violence victimization and perpetration among middle and high school students in a rural southern community. *Children and Youth Services Review*, 32(10), 1458-1463.
- McLeer, S. V., Deblinger, E., Atkins, M. S., Foa, E. B., & Ralphe, D. L. (1988). Posttraumatic stress disorder in sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 650-654.
- Merill, L. L., Thomsen, C. J., Sinclair, B. B., Gold, S. R., & Milner, J. S. (2001). Predicting the Impact of Child Sexual Abuse on Women: the role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology*, 69(6), 992-1006.
- Merryfield, E. A. (2001). *Application of the Rorschach in evaluating the traumagenic dynamics for adolescents sexually abused as children*. Retrieved from ProQuest Dissertations and Theses database. (UMI No. 3108294)
- Moak, Z. B., & Agrawal, A. (2009). The association between perceived interpersonal social support and physical and mental health: results from the national epidemiological survey on alcohol and related conditions. *Journal of Public Health*, 32(2), 191-201.
- Moran, P. B., & Eckenrode, J. (1992). Protective personality characteristics among adolescent victims of maltreatment. *Child Abuse & Neglect*, 16, 743-754.
- Morrisette, P. J. (1999). Posttraumatic Stress Disorder in Childhood sexual abuse: A synthesis and analysis of theoretical models. *Child and Adolescent Social Work Journal*, 16(2), 77-99.

- Mossakowski, K. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Social Behavior* 44(3), 318-331.
- Mullen, P. E., Martin, J. K., Anderson, J. C., & Herbison, G. P. (1994). The effect of sexual abuse on social, interpersonal, and adult sexual function in adult life. *The British Journal of Psychiatry*, 165, 35-47.
- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1996). The longterm impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse & neglect*, 20(1), 7-21.
- O'Leary, K. D., Malone, J., & Tyree, A. (1994). Physical aggression in early marriage: Pre-relationship and relationship effects. *Journal of Consulting and Clinical Psychology*, 62(3), 594-602.
- O'Leary, K. D., & Slep, A. M. (2003). A dyadic longitudinal model of adolescent dating aggression. *Journal of Clinical Child and Adolescent Psychology*, 32, 314-327.
- Operario, D., & Fiske, S.T. (2001). Ethnic identity moderates perceptions of prejudice: Judgments of personal versus group discrimination and subtle versus blatant bias. *Personality and Social Psychology Bulletin*, 27, 550-561.
- Orozco, V. (2007). *Ethnic identity, perceived social support, coping strategies, university environment, cultural congruity, and resilience of Latina/o college students*. Available from ProQuest Dissertations and Theses database. (UMI No. 3101340)
- Palmer, L., Farrar, A. R., & Ghahary, N. (2002). A bio-psychosocial approach to play therapy with maltreated children: The prescriptive elements in Erik Erikson's theory. In R R Massey & S. D. Massey (Eds.) & F. Kaslow (Series Ed.), *Comprehensive handbook of psychotherapy, Vol. 3. Interpersonal, humanistic, existential* (pp. 109 - 130). New York: Wiley.

- Palmer, L. K., Frantz, C., Annsworth, M., Swak, P., Copley, J., & Bush, G. (1999). Neuropsychological sequelae of chronically psychologically traumatized children: Specific findings in memory and higher cognitive functions. In L. Williams & V. Banyard (Eds.), *Trauma and memory* (pp. 229-244). Thousand Oaks, CA: Sage.
- Pelcovitz, D., van der Kolk, B. A., Roth, S., Mandel, F. S., Kaplan, S., & Resick, P. A. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10*, 3-17.
- Pereda, N., Guilera, G., Forns, M., & Gomez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review, 29*, 328-338.
- Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. In D. Schetky and E.P. Benedek (Eds.), *Textbook of Child and Adolescent Forensic Psychiatry*, (pp. 221-238). Washington, DC: American Psychiatric Press, Inc.
- Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma, 14*, 240-255.
- Perry, B. D., Pollard, R., Blakely, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain: how "states" become "traits". *Infant, 16*(4), 271-291.
- Perry, B., Conroy, L., & Ravitz, A. (1991). Persisting psychophysiological effects of traumatic stress: "The memory of states." *Violence Update, 1*(8), 1-11.
- Phinney, J. (1989). Stages of ethnic identity development in minority group adolescents. *Journal of Early Adolescence, 9*, 34-49.

- Phinney, J. (1990). Ethnic identity in adolescence and adulthood: A review of research: *Psychological Bulletin*, 108, 499-514.
- Phinney, J. (1992). The Multigroup ethnic identity measure: A new scale for use with diverse groups. *Journal of Adolescent Research* 7(2), 156-176.
- Phinney, J. (1993). A three-stage model of ethnic identity development. In M.B. Knight (Ed.), *Ethnic Identity: Formation and Transmission Among Hispanics and Other Minorities*. Albany, NY: State University of New York Press.
- Phinney, J. S. (1991). Ethnic identity and self-esteem: A review and integration. *Hispanic Journal of Behavioral Sciences*, 13(2), 193-208.
- Phinney, J. S., & Alipura, L. L. (1990). Ethnic identity in college students from four ethnic groups. *Journal of Adolescence*, 13, 171-183.
- Phinney, J. S., & Kohatsu, E. L. (1997). Ethnic and racial identity development and mental health. In J. Schulenberg, J. L. Maggs, & K. Hurrelmann (Eds.), *Health risks and developmental transitions during adolescence* (pp. 429-443). New York: Cambridge University Press.
- Phinney, J. S., Cantu, C. L., & Kurtz, D. A. (1997). Ethnic and American identity as predictors of self-esteem among African American, Latino, and white adolescents. *Journal of Youth and Adolescence*, 26(2), 165-185.
- Phinney, J.S. & Ong, A.D. (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. *Journal of Counseling Psychology*, 54, 3, 271-281.
- Pilkington, B., & Kremer, J. (1995). A review of the epidemiological research on child sexual abuse: Community and college student samples. *Child Abuse Review*, 4, 84-98.

- Polusny, M., & Follette, V. (1995). Long term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied and Preventative Psychology*, 4, 143–166.
- Portes, A., & Rumbaut, R. (2001). *Legacies: The story of the immigrant second generation*. Berkeley, CA: University of California Press.
- Price, E. L., Byers, E. S., & The Dating Violence Research Team (1999). The attitudes towards dating violence scales: Development and initial validation. *Journal of Family Violence*, 14(4), 351-375.
- Prince-Embury, S. (2008). Comparison of one-, two-, and three-factor models of personal resiliency using the resiliency scales for children and adolescents. *Canadian Journal of School Psychology*, 27(1). 11-25.
- Putnam, F. W. (2003). Ten-year research update review: Child sexual Abuse. *Journal of American Academy of Child and Adolescent Psychiatry*, 42(3), 269-278.
- Ralston, M.E. (1998). A community system of care for abused children and their families. *Family Futures*, 2(4), 11-15.
- Ralston, M.E. (1982). *Intrafamilial Sexual Abuse: A community system response to a family system problem*. Charleston, SC: Author.
- Ralston, M.E., & Swenson, C.C. (1996). *The Charleston Collaborative Project: Intervention Manual*. Charleston, SC: Author.
- Ramirez, J. M. (2009). *Child sexual trauma and traumagenic dynamics: the mediating role of family*. Available from ProQuest Dissertations and Theses database. (UMI No. 3383780)
- Reiker, P. P., & Carmen, E. (1986). The victim to patient process: The disconfirmation and transformation of abuse. *American Journal of Orthopsychiatry*, 56, 360-370.

- Richards, T.N.& Branch, K.A. (2012). The relationship between social support and adolescent dating violence: A comparison across genders. *Journal of Interpersonal Violence* 27(8), 1540-1561.
- Rogosch, F. A., Cicchetti, D., & Aber, J. L. (1995). The role of child maltreatment in early deviations in cognitive and affective processing abilities and later peer relationship problems. *Developmental Psychopathology*, 7, 591-609.
- Romero, A.J., & Roberts, R.E. (2003). The impact of multiple dimensions of ethnic identity on discrimination and adolescent self-esteem, *Journal of Applied Social Psychology*, 33(11), 2288-2305.
- Rosenthal, S., Feiring, C., & Taska, L. (2003). Emotional support and adjustment over a year's time following sexual abuse discovery. *Child Abuse & Neglect*, 27, 641-661.
- Roth, S., Pelcovitz, D., van Der Kolk, B. A., & Mandel, F. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trials for posttraumatic stress disorder. *Journal of Traumatic Stress*, 10, 539-555.
- Rotheram, M. J., &Phinney, J. S. (1987). Introduction: Definitions and perspectives in the study of children's ethnic socialization. In J. S. Phinney & M. J. Rotheram (Eds.), *Children's ethnic socialization* (pp. 10–28). Newbury Park, CA: Sage.
- Russell, D. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect*, 7, 133-146.
- Rutter M. (1987). Parental mental disorder as a psychiatric risk factor. In: Hales R, Frances A, editors. *American Psychiatric Association annual review*. Vol. 6. American Psychiatric Press, Inc.; Washington, DC: pp. 647–663.

- Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598-611.
- Saleebey, D. (1997). *The strengths perspective in social work practice*. New York: Longman.
- Saunders, B. E., & Meinig, M. B. (2000). Immediate issues affecting long term family resolution in cases of parent-child sexual abuse. In R.M. Reece (Ed.). *Treatment of Child Abuse: Common Ground for Mental Health, Medical, and Legal Practitioners*. Baltimore: The Johns Hopkins University Press.
- Saunders, B.E., & Meinig, M.B. (2001). *Family Resolution Therapy in Cases of Child Abuse*. Charleston, SC: Authors.
- Saunders, B. E., Vileponteaux, L. A., Lipovsky, J. A., Kilpatrick, D. G., & Vernonen, L. J. (1992). Child sexual assault as a risk factor for mental disorders among women: A community survey. *Journal of Interpersonal Violence*, 7, 189-204.
- Sedlak, A & Broadhurst, D. (1996). *Executive Summary of the Third National Incidence Study of Child Abuse and Neglect*. Washington, D.C.: National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services.
- Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress, Executive Summary*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.
- Senn, T. E., Carey, M. P., & Coury-Doniger, P. (2012). Mediators of the relation between childhood sexual abuse and women's sexual risk behavior: A comparison of two theoretical frameworks. *Archives Of Sexual Behavior*, 41(6), 1363-1377.
doi:10.1007/s10508-011-9897-z

- Singh, A. A. (2009). Helping South Asian immigrant women use resilience strategies in healing from sexual abuse: A call for a culturally relevant model. *Women & Therapy, 32*(4), 361-376.
- Smith, B. A., Thompson, S., Tomaka, J., & Buchanan, A. C. (2005). Development of the Intimate Partner Violence Attitudes Scales (IPVAS-R) with a predominantly Mexican American college sample. *Hispanic Journal of Behavioral Sciences, 27*, 442-454.
- Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin, 116*, 340-362.
- Spaccarelli, S., & Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect, 19*, 1171-1182.
- Spencer, M. B., & Markstrom-Adams, C. M. (1990). Identity processes among racial and ethnic minority children in America. *Child Development, 61*, 290-312.
- Tajfel, H., & Turner, J. (1986). The social identity theory of intergroup behavior. In Worchel, S. & Austin, W. (Eds.), *Psychology of Intergroup Relations* (p.7-24). Chicago, IL: Nelson-Hall.
- Tajfel, H. (1978). *The social psychology of minorities*. London: Minority Rights Group.
- Teja, S., & Stolberg, A. L. (1993). Peer support, divorce, and children's adjustment. *Journal of Divorce and Remarriage, 20*, 45-64.
- Temblay, C., Hebert, M., & Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect, 9*, 929-945.
- Terr, L. (1991). Childhood traumas. *American Journal of Psychiatry, 148*, 10-20.
- Tharinger, D. (1990). Impact of child sexual abuse on developing sexuality. *Professional Psychology: Research and Practice, 21*, 331-337.

- Tilden, V.P., & Weinert, S. C. (1987). Social support and the chronically ill individual. *Nursing Clinics of North America*, 22(3), 613-620.
- Tremblay, C., H'ebert M, & Pich' C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect*, 23(9), 929-945.
- Trickett P, Noll J, Reiffman A, Putnam F (2001), Variants of intrafamilial sexual abuse experiences: implications for short- and long-term development. *Developmental Psychopathology*, 13, 1001–1019.
- Ullman, S.E., (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors.. *Journal of Child Sexual Abuse*, 16(1), 19-36.
- United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>
- United States Government Accountability Office, (2011). Child maltreatment: strengthening national data on child fatalities could aid in prevention (GAO-11-599). Retrieved from <http://www.gao.gov/new.items/d11599.pdf>
- Ussher, J., & Dewberry, C., (1995). The nature and long-term effects of childhood sexual abuse: A survey of adult women survivors in Britain. *British Journal of Clinical Psychology*, 34, 177–192.
- van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35(5), 401-408.
- van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola. (2005). Disorders of extreme stress: the empirical foundation of complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), 389-399.

- Vranceanu, A., Hobfoll, S. E., & Johnson, R. J. (2007). Child multi-type maltreatment and associated depression and PTSD symptoms: the role of social support and stress. *Child Abuse & Neglect*, 31(1), 71-84.
- Walsh, C., MacMillan, H., & Jamieson, E. (2002). The relationship between parental psychiatric disorder and child physical and sexual abuse: Findings from the Ontario Health Supplement. *Child Abuse & Neglect*, 26, 11–22.
- Walsh, K., Galea, S., & Koenen, K. C. (2012). Mechanisms underlying sexual violence exposure and psychosocial sequelae: A theoretical and empirical review. *Clinical Psychology: Science And Practice*, 19(3), 260-275. doi:10.1111/cpsp.12004
- Wamser-Nanney, R., & Vandenberg, B. R. (2013). Empirical support for the definition of a complex trauma event in children and adolescents. *Journal Of Traumatic Stress*, 26(6), 671-678. doi:10.1002/jts.21857
- Weaver, D. E. (2009). *The relationship between cultural/ethnic identity and individual protective factors of academic resilience*. Available from ProQuest Dissertations and Theses database. (UMI No. 3371357)
- Wekerle, C., & Wolfe, D. A. (1998). The contribution of a history of child maltreatment and adolescent insecure attachment style to adolescent dating violence. *Development and Psychopathology*, 10, 571-586.
- Wekerle, C., & Wolfe, D. (1999). Dating violence in mid-adolescence: Theory, significance, and emerging prevention initiatives. *Clinical Psychology Review*, 19(4), 435-456.
- Wekerle, C., & Wolfe, D. A. (2003). Child maltreatment. In E.J. Mash & R.A. Barkley (Eds.), *Child psychopathology* (2nd ed., pp. 632-684). New York, NY: Guilford Press.

- Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: McGraw Hill.
- Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, NY: Cornell University Press.
- Widom, C. S., & Morris, S. (1997). Accuracy of adult recollections of childhood victimization, Part 2. Childhood sexual abuse. *Psychological Assessment*, 9, 34–46.
- Wills, T. A. (1985). Supportive functions of interpersonal relationships. In S. Cohen & S.L. Syme (Eds.), *Social support and health* (pp. 61-82). New York: Academic Press.
- Wilson, J., Smith, W., & Johnson, S. (1985). A comparative analysis of post-traumatic stress disorder among various survivor groups. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 142—172). New York: Brunner/Mazel.
- Wolfe, D. A., Wekerle, C., Scott, K., Straatman, A., & Grasley, C. (2004). Predicting abuse in adolescent dating relationships over 1 year: The role of child maltreatment and trauma. *Journal of Abnormal Psychology*, 113, 406-415.
- Wolfe, V. V., Gentile, C., & Wolfe, D. A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behavior Therapy*, 20, 215–228.
- Wolfe, V. V., Gentile, C., Michienzi, T., Sas, L., & Wolfe, D. A. (1991). The Children's Impact of Traumatic Events Scale: A measure of post sexual abuse PTSD symptoms. *Behavioral Assessment*, 13, 359–383.
- Wolfe, D., Sas, L., & Wekerle, C. (1994). Factors associated with the development of post-traumatic stress disorder among child victims of sexual abuse. *Child Abuse and Neglect*, 18, 37–50.

- Wolfe, D.A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., Straatman, A.L., (2001). Development and validation of the Conflict in Adolescent Dating Relationship Inventory. *Psychological Assessment*, 13(2), 277-293.
- Wolfe, V. V., & Wolfe, D. A. (1986). *The Sexual Abuse Fear Evaluation (SAFE): A subscale for the Fear Survey Schedule for Children-Revised*. Unpublished questionnaire, University of Western Ontario, London, Ontario.
- Wong, C. A., Eccles, J. S., & Sameroff, A. (2003). The influence of ethnic discrimination and ethnic identification on African American adolescents' school and socioemotional adjustment. *Journal of Personality*, 71, 1197-1232.
- World Health Organization, (2001). *WHO multi-country study on women's health and domestic violence*. (Preliminary results.) World Health Organization, Geneva.
- Wright, M. O., Fopma-Loy, J., & Fischer, S. (2005). Multidimensional assessment of resilience in mothers who are child sexual abuse survivors. *Child Abuse & Neglect*, 29(10), 1173-1193.
- Yip, T., & Fuligni, A. (2002). Daily variation in ethnic identity, ethnic behaviors, and psychological well-being among American adolescents of Chinese descent. *Child Development*, 73, 1557-1572.
- Yoo, H.C., & Lee, R.M. (2009). Does ethnic identity buffer or exacerbate the effects of frequent racial discrimination on situational well-being of Asian-Americans? *Journal of Counseling Psychology*, 55(1), 63-74.
- Zink, T., Klesges, L. M., Stevens, S., & Decker, P. (2009). The development of a sexual abuse severity score: Characteristics of childhood sexual abuse associated with trauma symptomology, somatization, and alcohol abuse. *Journal of Interpersonal Violence*, 24(3), 537-546.

Appendix A

LETTER OF SOLICITATION (guardian)

My name is Nita Makhija. I am a counseling psychology doctoral student in the Department of Professional Psychology and Family Therapy, at Seton Hall University, South Orange, New Jersey. I am conducting a study examining the emotional responses that result from child sexual abuse (CSA) and if they are related to the attitudes teenaged females have towards dating relationships. In examining this relationship, the severity of the abuse will be examined as a risk factor for having unhealthy attitudes towards romantic relationships and social support and ethnic identity will be examined as protective factors that support the development of healthy attitudes toward romantic relationships. This study hopes that gathering an understanding of adolescent's reactions to CSA will help in developing future interventions that can help children positively cope with the trauma of CSA.

I would like to ask if your child would be able to participate in my study. The estimated amount of time involved in your child participating in this research is approximately 30 minutes.

The procedures for the study are as follows:

Following your child's interview at the Newark Beth Israel Regional Diagnostic and Treatment Center (RDTC) permission to participate in the study will be obtained from you, your child's guardian. This research study is in no way connected to the RDTC interview and evaluation procedures. This research study is also not related to DYFS nor will it be discussed with DYFS. Following this your child will be asked to complete five questionnaires:

1. Demographic questionnaire asking about the child's age, gender, race, ethnicity, primary language spoken at home, religious affiliation, years living in US (if applicable), family composition, household composition, and relationship status.
2. Trauma-Related Beliefs Questionnaire which asks about traumatic responses your child may have experienced in relation to her abuse
3. Intimate Partner Violence Attitude Scale-Revised which asks about your child's attitudes towards violence in romantic relationships.
4. Survey of Children's Social Support, Family Subscale of the Social Support appraisals Scale which examines your child's perception of the support she gets from her family.
5. Multigroup Ethnic Identity Measure-Revised which measures your child's sense of ethnic identity.

Once the surveys are completed, your child will receive a \$5 gift card as a thank you for taking the time to participate in this study.

In addition to the five questionnaires your child fills out, the researcher will also fill out an additional measure. This measure is the Trauma Severity Checklist. This measure examines the types of abusive acts experienced by your child, the relationship of the perpetrator to your child, if the perpetrator was living with your child at the time of the abuse, the frequency of the abuse, how long the abuse lasted for and in what way your child was forced to participate in the abuse (i.e. physically harmed, threatened). Since asking your child these questions may be upsetting for her, the researcher requests your permission to obtain this information via accessing your child's records here at the RDTC at Newark Beth Israel Hospital.

If your child becomes upset or requests to end participation at any time during the study, she can stop and will receive the follow-up care she needs and a supervising psychologist will be informed.

Participation in the study is 100% optional. The study is in no way connected to the RDTC interview and has no bearing on the services you will receive at the RDTC. A child may decide not to do the study at any time and will not be penalized in any way. Each child's information will be given a random number code in order to keep yours or her name from being known. A sheet with the number code and contact information will be kept separate from the data. To be sure that others do not read your child's information, each child's personal information, responses, and contact information will be kept in a locked drawer at Newark Beth Israel Medical Center that only the researcher, Ms. Nita Makhija, her co-investigator, Dr. Karyn Smarz, and her supervisor, Dr. Laura Palmer, will have access. All data will be listed only by assigned number and will be kept in a different place from anything that has the child's name on it. The results of the research may be written in a professional journal or presented at a professional conference, in which the child's name, school, city, and state that they live will not be given. All of this information will be removed. For example, a made-up name will be used in place of the participant's name and the hospital will be listed as a hospital in northeast United States.

I appreciate your consideration of allowing your child to participate in this study.

Sincerely,

Nita Makhija, Ed.M.
Doctoral Candidate
Seton Hall University

Appendix B

LETTER OF SOLICITATION (minor)

Hi, my name is Nita Makhija. I am a student at Seton Hall University and I would like to invite you to take part in a research study I am doing. In this study I would like to find out more about the reactions teenage girls have to being sexually abused and if these reactions are related to their feelings about dating. I would also like to know if the severity of their abuse affects their reactions, or if their family support or feelings about their own ethnic identity affects their reactions. If you agree to join this study, you will be asked to answer some questions in some surveys. They will take about 30 minutes for you to complete. After you are done I would like to thank you for participating by giving you a \$5 gift card. I am asking you to join the study because you are a female adolescent between the ages of 12 and 15 who has come to Newark Beth Israel's Regional Diagnostic and Treatment Center for an interview. However, I want you to know that you do not have to participate in this study, and choosing to participate or not to participate will not affect your treatment at RDTC in any way.

There are six surveys in total that you will be filling out. No one else will see your responses except me. One survey will be filled out by me that asks about details of your abuse. In order to fill this survey out I am asking for your permission to get information from your records here at RDTC. The surveys that you will fill out ask questions regarding how you felt after you were abused, how you feel about dating, what kind of support you think your family gives you, and how you feel about your ethnicity.

I want to thank you for thinking about being a part of my study, I really appreciate it!

Sincerely,

Nita Makhija, Ed.M.
Doctoral Candidate
Seton Hall University

Appendix C

INFORMED CONSENT (guardian)

IRB # and Title of Study: The Relationship between Traumagenic Dynamic Responses toward Childhood Sexual Abuse, Social Support, Trauma Severity, and Attitudes toward Interpersonal Relationships in Adolescent Females

Principal Investigator, Department and/or Division, Co-investigators and names of all staff who can obtain consent

The principal investigator, Karyn Smarz, Ph.D is a supervising psychologist at the Regional Diagnostic and Treatment Center (RDTC). The other individuals involved in this study who may ask for your consent to participate in this study are the co-investigator, Nita Makhija a counseling psychology doctoral student in the Department of Professional Psychology and Family Therapy, at Seton Hall University, South Orange, New Jersey and an extern at the Regional Diagnostic Treatment Center (RDTC) at Newark Beth Israel Hospital, Alison Winston, Ph.D., supervising psychologist at RDTC, Zemed Berhe, Psychology Extern at RDTC, **or Marsha McMillan, Child Life Specialist at RDTC.**

Sponsor

N/A

Introduction

This form is asking for your informed consent for your child to participate in this study. When researchers ask for your consent, they are asking for your voluntary agreement to take part in a test, procedure, or clinical research trial. Informed consent means more than signing a printed consent form. To be informed, you need to know about benefits and risks of the clinical research trial and how it may affect you, your family and society. The following document is called a consent form and describes the clinical research trial and what your role will be as the study participant.

This consent may contain words that you do not understand. Please ask the individual in charge of the study, your own doctor or the staff involved with the clinical research trial to explain any words that you do not understand before signing this form, you will be given a copy of the signed consent form.

Your child is being invited to participate in this research study that examines the emotional responses that result from child sexual abuse (CSA) and if they are related to the attitudes teenaged females have towards dating relationships. Your child is being invited to participate because she is an adolescent girl who has come to the RDTC **to complete an interview or receive therapy** regarding the sexual abuse she experienced. Participation in this study is 100% optional. The study is in no way connected to the RDTC interview, **CHEC interview, or your child's therapy** and has no bearing on the services you will receive at the RDTC. A child may decide not to do the study at any time and will not be penalized in any way.

Purposes

This study is examining the emotional responses that result from child sexual abuse (CSA) and if they are related to the attitudes teenaged females have towards dating relationships. In examining this relationship, the severity of the abuse will be examined as a risk factor for having unhealthy attitudes towards romantic relationships and social support and ethnic identity will be examined as protective factors that keep a child from having an unhealthy attitude towards romantic relationships. This study hopes that gathering an understanding of children's reactions to CSA will help in developing future interventions that can help children positively cope with the trauma of CSA.

Participants, number, duration, inclusion and exclusion criteria.

77 adolescent girls are expected to participate in this study from the RDTC; only girls who come to the RDTC will be participating in this study. It is expected that your child will take 30 to 45 minutes to complete this study. Only adolescent girls (aged 13-18) who have experienced sexual abuse are being asked to participate in this study.

Procedures

Following the adolescent's **interview or therapy session** at the RDTC permission to participate in the study will be obtained from both the guardian and child. This research study is in no way connected to the **therapy, CHEC, or RDTC interview** or with DYFS. Following this the adolescent will be asked to complete five questionnaires regarding how she felt after she was abused, how she feels about dating, what kind of support she thinks her family gives her, and how she feel about her ethnicity. A sixth questionnaire will be filled out by the researcher that asks about details of her abuse. This questionnaire asks about the types of abusive acts experienced by your child, the relationship of the perpetrator to your child, if the perpetrator was living with your child at the time of the abuse, the frequency of the abuse, how long the abuse lasted for, in what way your child was forced to participate in the abuse (i.e. physically harmed, threatened), and if there was any occurrence of domestic violence in your child's home. Since asking your child these questions may be upsetting for her, the researcher requests your permission to obtain this information via accessing your child's records here at RDTC. By accessing these records your child does not have to answer these questions which may be distressing to her. If your child becomes upset or requests to end participation at any time during the study, she can stop and will receive the follow-up care she needs and a supervising psychologist will be informed. Once the surveys are completed, your child will receive a \$5 gift card as a thank you for participating.

Risks and Discomforts

This study may involve the following risks and discomforts to your child:

There is a chance that your child could get upset about some of the questions asked in the study. Any child that gets upset will be seen by the supervising psychologist who is present at RDTC at the time of your child's interview.

Benefits

Although there may be no benefits to you, there are potential benefits to others that may result from the knowledge gained. This study hopes that gathering an understanding of children's reactions to CSA will help in developing future interventions that can help children positively cope with the trauma of CSA.

Alternatives

The following treatments/procedures are available should you choose not to participate in this study: You may choose not to have your child participate in this study.

Confidentiality

The records of the participants in this study will be treated as confidential to the utmost of our ability. They may be made available, on a confidential basis, to the members of the Institutional Review Board and the staffs of regulatory agencies entitled by law to access those records. You will not be identified in any reports or publications resulting from the study.

Authorization To Use And Disclose Health Information (HIPAA 45 CFR Part 164)

This authorization concerns how your medical records and other health information will be used and disclosed for purposes of your participation in the Study.

This document specifically relates to uses and disclosures of your "protected health information" or "PHI" as referred to in federal law. For study purposes, your PHI may include records of your blood samples, physical examinations, test results, medical history and any other data collected or reviewed during the course of the study.

By signing this authorization, you are agreeing that your physicians and your other health care providers may provide Newark Beth Israel Medical Center and the investigators with the PHI they request for purposes of the study. You also are agreeing that Newark Beth Israel Medical Center and the investigators may, for purposes of the study, use your PHI collected or created as part of the study and share this information with the parties described below. Additionally, you are agreeing that, during the study, you may not have access to the PHI obtained or created as part of this study, although you will have access to this information once the study is finished.

Unless required by law, Newark Beth Israel Medical Center and the investigators will share your study PHI only with the Study Team and other professionals involved in the study;

The study sponsor: (there is no sponsor for this study) and its authorized agents; the U. S. Food and Drug Administration; governmental agencies as mandated; and the Newark Beth Israel

Medical Center Institutional Review Board (IRB). The purpose for sharing this information with these parties is to perform the study and to ensure the accuracy of the study data.

The specific PHI that will be released is as follows: (information pertaining to your child's sexual abuse, specifically: the types of abusive acts experienced by your child, the relationship of the perpetrator to your child, if the perpetrator was living with your child at the time of the abuse, the frequency of the abuse, how long the abuse lasted for and in what way your child was forced to participate in the abuse (i.e. physically harmed, threatened). This information will be used until 9/1/13. Not all of the parties who will have access to your PHI in connection with the study are prohibited by federal law from further sharing it, and the information, once received by them, may no longer be protected by federal law.

You have the right to cancel this authorization at any time by giving written notice to the investigators. If you cancel this authorization, then Newark Beth Israel Medical Center and the investigators will no longer use or disclose your PHI, unless it is necessary to do so to preserve the scientific integrity of the study. However, canceling this authorization will not affect previous uses and disclosures, and your PHI will not be removed from the study records.

You have the right to choose not to sign this authorization. You will not be denied non-research related treatment if you choose not to sign this authorization.

Unless you give your authorization by signing this document, or if you cancel your authorization later, you will not be eligible to participate in this study and will not receive any treatment provided as part of the study. If you do not cancel the authorization, it will remain valid and will not expire.

Costs

There are no costs associated with your child's participation in this study.

Payment (Include only if it applies)

As a thank you, your child will be given a \$5 gift card after she is done participating in the study.

In Case of Injury

In the event you believe you have suffered a study-related injury or illness, you should contact Karyn Smarz, Ph.D. at 973-926-6695.

Should you be injured in the course of this research study, you will be provided with necessary medical care. However, this statement does not mean that such medical care or hospitalization will be free. All charges will be billed to your insurance company or to you in the usual manner. Furthermore, no provisions have been made for financial compensation in the event of injury.

Contacts

If you have additional questions about this study, please contact Karyn Smarz, Ph.D. at 973-926-6695.

If you have questions about your rights as a participant in this research study, you should contact Dr. Victor Parsonnet, Chair of the Institutional Review Board of the Newark Beth Israel Medical Center, at (973) 926-7310.

You are encouraged to consult with anyone you choose, in private, about your participation in this study.

Voluntary Participation

Your participation in this study is voluntary. You may decide not to participate now, or to discontinue your participation at any time during the study. If you decide not to participate, or to end your participation during the study, you will not be penalized or lose any benefits to which you would be otherwise entitled.

You will be informed in writing of any significant new information that becomes available during the study that might affect your willingness to continue to participate in it.

The investigator or sponsor may end your participation if you need medical treatment not allowed during the study, if you fail to follow instructions, if you have a study-related injury, or for administrative reasons.

Agreement to Participate

I have read or been read this consent form, and have had an opportunity to ask questions about the study. All my questions have been answered to my satisfaction.

I am not giving up any of my legal rights by signing this form. I have been assured that I will receive a copy of the signed consent form. I voluntarily consent to the participation of my child in the study.

| | | |
|---|-----------|-------|
| _____ | _____ | _____ |
| Printed name of research participant | Signature | Date |
| _____ | _____ | _____ |
| Printed name of parent of minor, or of legal guardian/representative | Signature | Date |
| _____ | _____ | _____ |
| Printed name of witness | Signature | Date |

Printed name of person obtaining consent

Signature

Date

Attestation of the Investigator or Responsible Individual of obtaining Informed Consent

To the best of my knowledge _____ (name of study participant's parent/legal guardian) has assimilated the entire content of the above consent form, and understands the study and its risks well. The subject's questions and those of his/her parent or legal guardian have been accurately answered to his/her/their complete satisfaction.

Printed name of investigator/

Signature

Date

Appendix D

ASSENT (Minors)

I would like to find out if you are interested in taking part in a research study I am doing. In my study I would like to find out more about the reactions teenaged girls have to being sexually abused, if these reactions are related to their feelings about dating I would also like to know if the severity of their abuse affects their reactions, or if their family support or feelings about their own ethnic identity affects their reactions. I am asking you to join the study because you are a female adolescent between the ages of 13 and 18 who has come to Newark Beth Israel's Regional Diagnostic and Treatment Center for an interview or therapy. However, I want you to know that you do not have to participate in this study, that it is not connect to DYFS in any way, and choosing to participate or not to participate will not affect your treatment at RDTC in any way.

If you agree to join this study, you will be asked to answer some questions in some surveys. There are five surveys in total that you will be filling out. These surveys ask questions regarding how you felt after you were abused, how you feel about dating, what kind of support you think your family gives you, and how you feel about your ethnicity. Also, I need to fill out one survey myself. This survey asks about the abuse you experienced. Because I don't want to upset you by asking you details about this, I am asking for your permission to get this information from your file here at RDTC. The questions I will be answering in this survey are: what the abuse was, how they made you listen to them, how often it occurred, how long it lasted for who did it, where that person lived, and if there was any domestic violence that ever took place in your household.

It is possible that when you think about some of the questions, you may start to feel upset. If this feeling of sadness becomes strong, you can let the researcher know. You may also decide you do not want to do the study anymore, which is completely okay. Just let me know by saying that you are done and you can immediately stop.

When you have completed the questionnaires I would like to thank you by giving you a \$5 gift card.

"This study has been explained to me. I have had a chance to ask questions about it, and I am satisfied with the answers I have received. I am willing to participate in the study."

Printed name of minor research participant

Signature

Date

Appendix E

Demographic Questionnaire

Please answer each question below.

- 1) Age: _____
- 2) Grade in School: _____
- 3) Gender: _____
- 4) Race/Ethnicity:

| | |
|-------------------------------|-------------------------------------|
| _____ Black/ African American | _____ Asian |
| _____ Hispanic/ Latino | _____ Mixed Race or Mixed Ethnicity |
| _____ White/ Caucasian | _____ Other |
- 5) Primary Language Spoken at Home _____
- 6) Religious Affiliation: _____
- 7) Years living in the U.S. _____
- 8) Who is in your family? (Please check all that apply)

| |
|-------------------------------------|
| _____ Mother |
| _____ Father |
| _____ Step-Mother |
| _____ Step-Father |
| _____ Brother: how many? _____ |
| _____ Sister: how many? _____ |
| _____ Step-brother: how many? _____ |
| _____ Step-sister: how many? _____ |
| _____ Other: who? _____ |
- 9) Who lives in your home? (Please check all that apply)

| |
|--------------------------------|
| _____ Mother |
| _____ Father |
| _____ Step-Mother |
| _____ Step-Father |
| _____ Brother: how many? _____ |

_____ Sister: how many? _____
 _____ Step-brother: how many? _____
 _____ Step-sister: how many? _____
 _____ Grandmother
 _____ Grandfather
 _____ Aunt
 _____ Uncle
 _____ Parent's significant other
 _____ unrelated individuals:
 who? _____
 _____ other: _____

10) Are you currently living with a foster family or have you lived with one in the past?

_____ Never have lived with a foster family
 _____ Currently living with a foster family
 If so, for how long? _____
 _____ Lived with a foster family in the past
 If so, when? _____
 And for how long? _____

11) Your relationship Status:

_____ In a relationship
 _____ Single

12) Are you currently or have you previously received therapy or counseling?

| | |
|-----------------------------------|------------------------------------|
| _____ Never have received therapy | _____ Received therapy in the past |
| _____ Currently receiving therapy | If so, when? _____ |
| If so, for how long? _____ | And for how long? _____ |

Appendix F

Trauma Related Beliefs Questionnaire (TRB; Haazard, 1993)

Directions:

Below are some statements of different thoughts and feelings. Some statements are about what happened in the past, in other words, your experience(s) of sexual abuse. Other statements are about your current views concerning various issues. For each statement, please circle one number to indicate how untrue or true the statement is to you. The rating scale is as follows:

| 0= Absolutely untrue | 1= Mostly untrue | 2= Partly true, partly untrue | 3= Mostly true | 4=Absolutely true | |
|---|------------------|-------------------------------|----------------|-------------------|---|
| 1. People often take advantage of others | 0 | 1 | 2 | 3 | 4 |
| 2. Thinking about sex upsets me. | 0 | 1 | 2 | 3 | 4 |
| 3. I was to blame for what happened. | 0 | 1 | 2 | 3 | 4 |
| 4. I often wonder “why me?” | 0 | 1 | 2 | 3 | 4 |
| 5. I feel I should be punished for what I did. | 0 | 1 | 2 | 3 | 4 |
| 6. Most things in life can’t be controlled | 0 | 1 | 2 | 3 | 4 |
| 7. Something like this might happen to me again. | 0 | 1 | 2 | 3 | 4 |
| 8. The abuse happened to me because I was not smart enough to stop it from happening . | 0 | 1 | 2 | 3 | 4 |
| 9. No matter what I do, I can’t stop bad things from happening . | 0 | 1 | 2 | 3 | 4 |
| 10. I get frightened when I think about sex. | 0 | 1 | 2 | 3 | 4 |
| 11. I wish there was no such thing as sex. | 0 | 1 | 2 | 3 | 4 |
| 12. The abuse was my fault because I used sexual activities to obtain attention or rewards from the abuser. | 0 | 1 | 2 | 3 | 4 |
| 13. Most other abuse victims are coping better than I am. | 0 | 1 | 2 | 3 | 4 |
| 14. If you love someone, sooner or later that person will let you down. | 0 | 1 | 2 | 3 | 4 |
| 15. I often worry that I will be abused again. | 0 | 1 | 2 | 3 | 4 |
| 16. Sex is dirty. | 0 | 1 | 2 | 3 | 4 |
| 17. I can protect myself in the future. | 0 | 1 | 2 | 3 | 4 |
| 18. The person who abused me was to blame for what happened. | 0 | 1 | 2 | 3 | 4 |
| 19. I did what most children would do in similar circumstances. | 0 | 1 | 2 | 3 | 4 |
| 20. Nobody really cares about anyone but themselves. | 0 | 1 | 2 | 3 | 4 |
| 21. I can’t control what happens to me. | 0 | 1 | 2 | 3 | 4 |
| 22. Sex is disgusting. | 0 | 1 | 2 | 3 | 4 |
| 23. I feel guilty about what happened. | 0 | 1 | 2 | 3 | 4 |
| 24. I am inferior to other people because I did not have normal experiences. | 0 | 1 | 2 | 3 | 4 |
| 25. I believe something positive has come out of my abuse. | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|--|---|---|---|---|---|
| 26. I can depend on close friends to help me. | 0 | 1 | 2 | 3 | 4 |
| 27. More bad things happen to me than to other people. | 0 | 1 | 2 | 3 | 4 |
| 28. I can usually achieve what I want in most situations. | 0 | 1 | 2 | 3 | 4 |
| 29. Sex is beautiful. | 0 | 1 | 2 | 3 | 4 |
| 30. This happened to me because I always have bad luck. | 0 | 1 | 2 | 3 | 4 |
| 31. I must have permitted sexual activities because I wasn't forced into it. | 0 | 1 | 2 | 3 | 4 |
| 32. I just don't understand why this happened. | 0 | 1 | 2 | 3 | 4 |
| 33. I should be handling this better than I am. | 0 | 1 | 2 | 3 | 4 |
| 34. This happened to me because I am a bad person. | 0 | 1 | 2 | 3 | 4 |
| 35. I should have been able to prevent the abuse. | 0 | 1 | 2 | 3 | 4 |
| 36. I am ashamed about what happened. | 0 | 1 | 2 | 3 | 4 |
| 37. I have to know people for a long time before I can trust them. | 0 | 1 | 2 | 3 | 4 |
| 38. I am embarrassed when I see people who know what happened. | 0 | 1 | 2 | 3 | 4 |
| 39. I have found a way to make sense of what happened. | 0 | 1 | 2 | 3 | 4 |
| 40. People always expect something in return for being nice. | 0 | 1 | 2 | 3 | 4 |
| 41. It doesn't pay to try hard because things never turn out right anyway. | 0 | 1 | 2 | 3 | 4 |
| 42. I hate sex. | 0 | 1 | 2 | 3 | 4 |
| 43. I was too young to stop this from happening. | 0 | 1 | 2 | 3 | 4 |
| 44. It is unnatural to feel any pleasure during sexual abuse. | 0 | 1 | 2 | 3 | 4 |
| 45. Most men are trustworthy. | 0 | 1 | 2 | 3 | 4 |
| 46. I was tricked into the abuse. | 0 | 1 | 2 | 3 | 4 |
| 47. My passivity encouraged the abuse to continue. | 0 | 1 | 2 | 3 | 4 |
| 48. I will never be able to lead a normal life. | 0 | 1 | 2 | 3 | 4 |
| 49. I feel I have caused trouble for many people. | 0 | 1 | 2 | 3 | 4 |
| 50. I am different than other people. | 0 | 1 | 2 | 3 | 4 |
| 51. It is dangerous to get close to anyone because they always betray you. | 0 | 1 | 2 | 3 | 4 |
| 52. You can't depend on women. | 0 | 1 | 2 | 3 | 4 |
| 53. People don't have much influence over the way things turn out. | 0 | 1 | 2 | 3 | 4 |
| 54. It is hard to tell the difference between affection and sexual touching. | 0 | 1 | 2 | 3 | 4 |
| 55. There were good reasons for the choices I made as a child. | 0 | 1 | 2 | 3 | 4 |
| 56. This happened to me because I am not a strong person. | 0 | 1 | 2 | 3 | 4 |

Appendix G

Intimate Partner Violence Attitude Scale-Revised (IPVAS-R-R ; Fincham, Cui, Braithwaite, and Pasley, 2008).

Directions: Below are some statements of different thoughts and feelings in relation to dating relationships. For each statement, please circle one number to indicate how much you disagree or agree. The rating scale is as follows:

1=Strongly Disagree 2=Disagree 3- Neither Agree or Disagree 4= Agree 5=Strongly Agree

| | | | | | |
|---|---|---|---|---|---|
| 1.I would be flattered if my partner told me not to talk to someone of the opposite sex. | 1 | 2 | 3 | 4 | 5 |
| 2. I would not like for my partner to ask me what I did every minute of the day. | 1 | 2 | 3 | 4 | 5 |
| 3. It is okay for me to blame my partner when I do bad things. | 1 | 2 | 3 | 4 | 5 |
| 4. I don't mind my partner doing something just to make me jealous. | 1 | 2 | 3 | 4 | 5 |
| 5. I would not stay with a partner who tried to keep me from doing things with other people. | 1 | 2 | 3 | 4 | 5 |
| 6. as long as my partner doesn't hurt me, "threats" are excused. | 1 | 2 | 3 | 4 | 5 |
| 7. During a heated argument, it is okay for me to bring up something from my partner's past to hurt him or her. | 1 | 2 | 3 | 4 | 5 |
| 9. I would never try to keep my partner from doing things with other people. | 1 | 2 | 3 | 4 | 5 |
| 9. I think it helps our relationship for me to make my partner jealous. | 1 | 2 | 3 | 4 | 5 |
| 10. It is no big deal if my partner insults me in front of others. | 1 | 2 | 3 | 4 | 5 |
| 11. It is okay for me to tell my partner not to talk to someone of the opposite sex. | 1 | 2 | 3 | 4 | 5 |
| 12. Threatening a partner with a knife or gun is never appropriate. | 1 | 2 | 3 | 4 | 5 |
| 13. I think it is wrong to ever damage anything that belongs to a partner. | 1 | 2 | 3 | 4 | 5 |
| 14. It would not be appropriate to ever kick, bite, or hit a partner with one's fist. | 1 | 2 | 3 | 4 | 5 |
| 15. It is okay for me to accept blame for my partner doing bad things. | 1 | 2 | 3 | 4 | 5 |
| 16. During a heated argument, it is okay for me to say something just to my partner on purpose. | 1 | 2 | 3 | 4 | 5 |
| 17. It would never be appropriate to hit or try to hit one's partner with an object. | 1 | 2 | 3 | 4 | 5 |

Appendix H

Family Subscale of the Social Support Appraisals Scale (APP) of the Survey of Children's Social Support (SCSS; Dubow & Ullman, 1989)

Directions: Please circle always, most of the time, sometimes, hardly ever, or never for each question.

1. Some kids can count on their family for help or advice when they have problems, but other kids cannot. Can you count on your family for help or advice when you have problems?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

2. Some kids and their families do a lot of things for each other, but other kids and their families don't. Do you and your family do a lot of things for each other?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

3. Some kids' families make them feel bad, but other kids' families don't. Does your family make you feel bad?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

4. Some kids share a lot with their family, but other kids don't. Do you share a lot with your family?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

5. Some kids have a hard time talking to their family, but other kids don't. Do you have a hard time talking to your family?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

6. Some kids feel like their family is there when they need them, but other kids don't feel this way. Do you feel like your family is there when you need them?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | never |
| (1) | (2) | (3) | (4) | (5) |

7. Some kids feel left out by their family, but other kids don't. Do you feel left out by your family?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | never |
| (1) | (2) | (3) | (4) | (5) |

8. Some kids' families ignore their ideas, but other kids' families don't. Does your family ignore your ideas?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | never |
| (1) | (2) | (3) | (4) | (5) |

9. Some kids are an important member of their family, but other kids are not. Are you an important member of your family?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | never |
| (1) | (2) | (3) | (4) | (5) |

10. Some kids think their families really care about them, but other kids think their families don't. Do you think your family cares about you?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | never |
| (1) | (2) | (3) | (4) | (5) |

11. Some kids feel like they belong in their family, but other kids feel like they don't belong. Do you feel like you belong in your family?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

12. Some kids think their families are mean to them, but other kids don't. Do you think your family is mean to you?

| | | | | |
|--------|------------------|-----------|-------------|-------|
| always | most of the time | sometimes | hardly ever | Never |
| (1) | (2) | (3) | (4) | (5) |

Appendix I

Multigroup Ethnic Identity Measure-Revised (MEIM-R; Phinney & Ong, 2007).

Directions: Below are some statements regarding your thoughts, feelings and behaviors towards your ethnic group. For each statement, please circle one number to indicate how much you disagree or agree. The rating scale is as follows:

| 1= Strongly Disagree | 2= Disagree | 3= Neither Agree or Disagree | 4= Agree | 5=Strongly Agree | |
|--|-------------|------------------------------------|----------|---------------------|---|
| 1. I have spent time trying to find out more about my ethnic group, such as its history, traditions and customs. | 1 | 2 | 3 | 4 | 5 |
| 2. I have a strong sense of belonging to my own ethnic group. | 1 | 2 | 3 | 4 | 5 |
| 3. I understand pretty well what my ethnic group membership means to me. | 1 | 2 | 3 | 4 | 5 |
| 4. I have often done things that will help me understand my ethnic background better. | 1 | 2 | 3 | 4 | 5 |
| 5. I have often talked to other people in order to learn more about my ethnic group. | 1 | 2 | 3 | 4 | 5 |
| 6 I feel a strong attachment towards my own ethnic group. | 1 | 2 | 3 | 4 | 5 |

Appendix J

Sexual Abuse Severity Score (Zink, Klesges, Stevens, & Decker (2009))

Directions: Allocate points as indicated for each abuse characteristic (to be filled out by assessor)

| Factor | Points allocated |
|--|------------------|
| Age of first sexual abuse | |
| 3–4 | 7 |
| 5–6 | 6 |
| 7–8 | 5 |
| 9–10 | 4 |
| 11–12 | 3 |
| 13–14 | 2 |
| 15–16 | 1 |
| ≥17 | 0 |
| Number of perpetrators | |
| 1 | 0 |
| ≥2 | 1 |
| Maximum coercion ever experienced | |
| High (i.e., Physical force or weapons) | 4 |
| Moderate (i.e., Threats, bribes or verbal force) | 2 |
| None | 0 |
| Most severe abuse ever experienced | |
| Attempted intercourse, intercourse, or inserting an object | 4 |
| Fondling or being fondled, touching other's sex organ or sex organ being touched | 2 |
| Request of sex, kissing, other showing sex organ, or other looking at your sex organ | 0 |
| Number of occurrences of abuse | |
| 1 | 0 |
| 2 | 1 |
| 3 | 2 |
| 4–9 | 3 |
| ≥10 | 4 |

Total Score _____

Does the participant currently live in a home in which domestic violence occurs (one of the participant's caretakers behaves violently towards another one of the participant's caretakers)?

Has the participant ever lived in a home in which domestic violence occurs?